FINAL REPORT OF THE SOCIAL SECURITY DISABILITY ADVISORY COUNCIL

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

MAY 26, 1988

Serial 100-72

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
89-993 WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H781-21

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida
J.J. PICKLE, Texas
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, Jr., Indiana
HAROLD FORD, Tennessee
ED JENKINS, Georgia
RICHARD A. GEPHARDT, Missouri
THOMAS J. DOWNEY, New York
FRANK J. GUARINI, New Jersey
MARTY RUSSO, Illinois
DON J. PEASE, Ohio
ROBERT T. MATSUI, California
BERYL ANTHONY, Jr., Arkansas
RONNIE G. FLIPPO, Alabama
BYRON L. DORGAN, North Dakota
BARBARA B. KENNELLY, Connecticut
BRIAN J. DONNELLY, Massachusetts
WILLIAM J. COYNE, Pennsylvania
MICHAEL A. ANDREWS, Texas
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin

JOHN J. DUNCAN, Tennessee
BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
DICK SCHULZE, Pennsylvania
BILL GRADISON, Ohio
WILLIAM M. THOMAS, California
RAYMOND J. McGRATH, New York
HAL DAUB, Nebraska
JUDD GREGG, New Hampshire
HANK BROWN, Colorado
ROD CHANDLER, Washington

Robert J. Leonard, *Chief Counsel*
M. Kenneth Bowler, *Staff Director*
A.L. Singleton, *Minority Chief of Staff*

Subcommittee on Social Security

ANDY JACOBS, Jr., Indiana, *Chairman*

RICHARD A. GEPHARDT, Missouri
SAM M. GIBBONS, Florida
SANDER M. LEVIN, Michigan
JIM MOODY, Wisconsin

BILL ARCHER, Texas
PHILIP M. CRANE, Illinois
HAL DAUB, Nebraska

CONTENTS

Page

Press release of May 12, 1988, announcing the hearing 2

WITNESSES

Disability Advisory Council, John E. Affeldt, M.D. 4

U.S. Department of Health and Human Services, Social Security Administration, David A. Rust, Associate Commissioner for the Office of Disability; Malcolm H. Morrison, Director, Division of Disability Program Information and Studies, Office of Disability; and John Ritter, Executive Program Policy Officer, Office of Disability 33

U.S. General Accounting Office, Franklin Frazier, Associate Director, Human Resources Division; Ken Libbey, Evaluator in Charge; and Cameo Zola, Assignment Manager 47

American Foundation for the Blind, Scott Marshall 57

Association for Retarded Citizens of the United States, Elizabeth M. Boggs 121

Bartlett, Hon. Steve, a Representative in Congress from the State of Texas 14

Council of State Administrators of Vocational Rehabilitation, Joseph A. Snyder, Pennsylvania Office of Vocational Rehabilitation 74

National Alliance for the Mentally Ill, Jim Havel 116

National Association of Disability Examiners, David Tschetter and Michael Brennan 87

National Association of Rehabilitation Professionals in the Private Sector, Bill Roberts 83

National Committee To Preserve Social Security and Medicare, William J. Lessard, Jr 108

National Council on Independent Living, Robert Gorski 64

National Federation of the Blind, Marc Maurer 93

National Head Injury Foundation, Bartolomeo Larichiuta 115

National Mental Health Association, Michael Wilson 69

Paralyzed Veterans of America, R. Dennis Smurr 101

Save Our Security Coalition, Arthur S. Flemming 52

APPENDIX

Questions and responses of some of the witnesses 129

SUBMISSIONS FOR THE RECORD

Branca, Edward, Jr., Garnerville, N.Y., statement 142

Electronic Industries Association and Electronic Industries Foundation, Peter F. McClosky, joint letter 144

National Association of Rehabilitation Facilities, statement 147

National Industries for the Blind, George J. Mertz, statement 153

National Multiple Sclerosis Society, John Donnelly, statement 156

Thomason, George H., Thomason & French, Spartanburg, S.C., letter 161

FINAL REPORT OF THE SOCIAL SECURITY DISABILITY ADVISORY COUNCIL

THURSDAY, MAY 26, 1988

House of Representatives,
Committee on Ways and Means,
Subcommittee on Social Security,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room B-318, Rayburn House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, MAY 12, 1988

SUBCOMMITTEE ON SOCIAL SECURITY #10
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1721

ANDY JACOBS, JR., (D., IND.), CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE FINAL REPORT OF THE SOCIAL SECURITY DISABILITY ADVISORY COUNCIL ON THURSDAY, MAY 26, 1988, AT 10:00, A.M., IN ROOM B-318, RAYBURN HOUSE OFFICE BUILDING

Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on the final report of the Social Security Disability Advisory Council, issued March 11, 1988. The hearing will be held on May 26, 1988, in room B-318 Rayburn House Office Building, beginning at 10:00 a.m.

The Disability Advisory Council was established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). In fulfilling its mandate, the Council examined four major issues: (1) the nature of work incentives and disincentives in the social security disability insurance (SSDI) and Supplemental Security Income programs (SSI), (2) the effectiveness of vocational rehabilitation for SSDI and disabled SSI beneficiaries; (3) the use of specialists in medical and vocational evaluations by State disability determination agencies; and (4) the role of work evaluations in assessing disability.

The Subcommittee hearing will focus on the Council's findings and recommendations concerning social security disability insurance, as well as on a related report by the General Accounting Office, "Little Success Achieved in Rehabilitating Disabled Beneficiaries" (GAO/HRD-88-11, December, 1987). In this report, the GAO identified reasons for the low rate of rehabilitation of SSDI beneficiaries and recommended that Congress consider requiring the Social Security Administration to experiment with changes in the structure of benefit payments to encourage beneficiaries to work. In seeking testimony on both reports, the Subcommittee encourages witnesses to focus particular attention on work incentives and disincentives in the SSDI program; on the changes recommended by the reports in the structure of payments to SSDI beneficiaries (including Substantial Gainful Activity, trial work, and sliding-scale benefit reductions); on the changes recommended in the administrative framework for vocational rehabilitation; and on the adequacy of existing information concerning the work potential of SSDI beneficiaries.

REQUESTS TO BE HEARD:

Requests to be heard at the hearing must be made by telephone to Harriett Lawler or Diane Kirkland [(telephone (202) 225-1721)] by the close of business Thursday, May 19, 1988. In order to facilitate scheduling, requests should indicate the specific issues that the witness wishes to address and the relative priority of each issue if more than one issue is indicated. The request should be followed by a formal written request addressed to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee staff [(202) 225-9263)].

In view of the limited time available to hear witnesses the Subcommittee may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testmony or not, will be notified as soon as possible after the filing deadline.

Witnesses scheduled to present oral testimony are required to summarize briefly their written statements in no more than five minutes. THE FIVE-MINUTE RULE WILL BE STRICTLY APPLIED. The full statement will be included in the printed record.

In order to assure the most productive use of the limited amount of time available to question witnesses, those scheduled to appear before the Subcommittee are required to submit 100 copies of their prepared statements to the Subcommittee on Social Security office, room B-316 Rayburn House Office Building, at least 24 hours in advance of their scheduled appearances. Failure to do so may result in the witness being denied the opportunity to testify in person.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Persons submitting written comments for the printed record of the hearing should submit six (6) copies by the close of business, Thursday, June 9, 1988, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing a written statement for the record of the printed hearing wish to have their statements distributed to the press and the interested public at the hearing, they may provide 75 additional copies for this purpose to the Subcommittee office, room B-316 Rayburn House Office Building, during the course of the public hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman Jacobs. The hearing will come to order.

This morning the Social Security Subcommittee is hearing testimony on the report of the Social Security Disability Advisory Council. Will the first witness please come forward, while I find out who you are. Steve Bartlett. Steve Bartlett, our colleague, is our first witness.

Failing in that, John Affeldt, Chairman of the Advisory Council. You know the rules of the New York State Athletic Commission, so just proceed.

STATEMENT OF JOHN E. AFFELDT, M.D., CHAIRMAN, DISABILITY ADVISORY COUNCIL

Dr. Affeldt. Mr. Chairman, members of the subcommittee, my name is John Affeldt. I am the medical adviser for Beverly Enterprises and was honored to serve as the Chairman of the Disability Advisory Council. I am pleased to have the opportunity to appear before you today, and I will submit a statement for the record.

Secretary Bowen appointed the Disability Advisory Council as directed by Public Law 99-272. The Council included representatives of employers and employees, public and private vocational rehabilitation providers, disability advocacy groups, medical experts, and the general public.

The statute that directed the Secretary to appoint the Council set forth several areas of inquiry: The effectiveness of vocational rehabilitation for the DI and SSI disabled and blind recipients, the use of work evaluations in the disability determination process and the question of requiring medical specialists to complete determinations of disabilities in cases that do not involve mental impairments.

In addition, the Commissioner of Social Security, Dorcas R. Hardy, asked that the Council examine ways of eliminating disincentives to work and enhancing incentives to work. Finally, the Council's deliberations led it to examine variations in allowance rates across the States and reversal rates by the administrative law judges and Federal judges.

After 13 meetings and 4 field hearings, the Council unanimously agreed to its final report to the Secretary on December 8, 1987, and I have a copy of that report here which I am sure has been submitted to you. The Council's report consists of three parts and contains 51 specific recommendations. The first part labeled "Matters of Overarching Concern," identified what we call confusion of program goals. The Council believes that one of the central problems in the DI and SSI programs is that Congress has not clearly defined the purpose and goals for the program.

How can SSA reconcile the program goal of determining that an applicant's work incapacity is total and long-lasting with the goal of enhancing an applicant's capacity to work? From the beneficiary's perspective, the problem is one of mixed signals. They must prove that they cannot work in order to be awarded benefits. Then they are encouraged to return to work and forfeit their benefits.

The Council believes that in the long term, the emphasis of these programs should fall on moving disabled people into the labor force rather than on declaring them permanently disabled to work at the outset. If there is any one statement that would encapsulate the feeling of the Council and, therefore, impact the recommendations, it is this one, and I am going to repeat it. The Council believes that in the long term the emphasis of these programs should fall on moving disabled people into the labor force rather than on declaring them permanently unable to work at the outset.

In order to maximize the number of people with disabilities who become gainfully employed, the Council believes that Congress must restructure these programs, but such restructuring should not be done immediately, new approaches should first be tested to assure they are workable and cost effective and they accomplish their stated goals. Emphasis should be placed on encouraging applicants to work rather than on establishing that they are unable to work.

The second part deals with issues related to employment of the disabled beneficiaries such as vocational rehabilitation. The Council believes that VR has not been effective for the disabled and blind recipients of DI and SSI. The Council attributes this lack of effectiveness to a number of causes, including lack of data about the characteristics of beneficiaries, lack of coordination between SSA and the RSA, the Rehabilitation Services Administration, lack of knowledge among employers and the general public about the capabilities of people with disabilities.

Looking at VR, work incentives and disincentives, this part of the report contains the bulk of the recommendations, 35 in fact. The recommendations include methods to improve coordination between SSA and RSA, modifications to the reimbursement procedure and provisions for better individual State and private-sector participation in VR programs.

The Council also recommends that the amounts of earnings that constitute SGA and trial work months be raised and that SSA conduct an extensive information campaign regarding work incentive provisions in current law. Other recommendations deal with extending the rights of persons with disabilities and exploring tax incentives as a means for getting people with disabilities to work.

The third part of the report addresses issues related to the determination of disability. The Council believes SSA's overriding concerns should be to achieve nationwide uniformity in disability decisions and to insure that accurate decisions are made as early in the process as is practicable.

The Council also believes that variations in State-by-State allowance rates are too high, the rates of reversal by the administrative law judges are too high, and the length of time it takes to appeal disability decisions is great, resulting in a hardship to applicants and unnecessary cost to them and to the Federal Government.

The next chapter is the use of medical specialists in determination of disability. The Council heard much testimony to the effect that medical specialists are not routinely needed for adjudication of disability claims that do not involve allegations of mental impairment and that DDS's use specialty review when appropriate. The Council agreed demanding specialty review would not be appropriate.

And, last, on the use of work evaluations, the Council does not recommend mandating work evaluations.

This concludes my testimony, and I will be happy to answer any questions.

[The statement of John E. Affeldt follows:]

STATEMENT OF JOHN E. AFFELDT, M.D., CHAIRMAN, DISABILITY ADVISORY COUNCIL

Mr. Chairman, members of the Subcommittee, my name is John E. Affeldt. I am the medical advisor for Beverly Enterprises and was honored to have served as the chairman of the Disability Advisory Council. I am pleased to have the opportunity to appear before you today to discuss the findings of the Council. The Council was appointed by the Secretary of Health and Human Services, Otis R. Bowen, pursuant to Section 12102 of "The Consolidated Budget Reconciliation Act of 1985." The Council was charged to study and make recommendations to the Secretary with respect to the medical and vocational aspects of disability under both titles II and XVI of the Social Security Act. We held our first meeting in November 1986. After 13 meetings and four field hearings, and after receiving testimony from more than 100 witnesses and correspondence from hundreds of groups and individuals, the Council unanimously approved its final report on December 8, 1987. The report was submitted by Secretary Bowen to the Congress on March 11. I am told that this was the first ever Social Security Advisory Council to achieve unanimous consent on its report.

Before I discuss the contents of the report and the Council's recommendations, I would like to thank my fellow council members for their open mindness, social consciousness, perserverance and indefatigability. Without these strengths I do not believe that we would have been able to complete successfully our important and challenging task. I would also like to thank the Commissioner of Social Security, Dorcas R. Hardy, for her very strong support by providing a very dedicated and competent group of staff who gathered, analyzed and developed background material for the Council.

The Secretary assembled a unique group of individuals who brought diverse perspectives to the issues that the Council was charged to address. The Council included representatives of employers and employees, public and private vocational rehabilitation providers, disability advocacy groups, medical and vocational experts and the general public. From the very beginning of our deliberations we committed ourselves to a course that would provide encouragement to disabled people to work and achieve their full potential. Our report and the 51 recommendations contained therein fully reflect that committment.

It was my unique pleasure and honor to have worked with such a knowledgeable and dedicated group. I am very proud of what we accomplished.

ISSUES STUDIED BY THE COUNCIL

The statute that directed the Secretary to appoint the Council set forth several areas of inquiry into the disability programs administered by the Social Security Administration (SSA):

- The effectiveness of vocational rehabilitation (VR) for recipients of Social Security disability insurance (DI) or Supplemental Security Income (SSI) benefits;
- The use of work evaluations in the disability determination process; and
- The question of requiring medical specialists to complete determinations of disabilities in cases that do not involve mental impairments.

In addition, Commissioner Hardy asked the Council to examine ways of eliminating disincentives to work and enhancing incentives to work in the DI and SSI programs.

Finally, the Council's deliberations led us to examine variations in allowance rates across States and reversal rates by administrative law judges and Federal judges.

BACKGROUND ON THE COUNCIL'S DELIBERATIONS

Our inquiry into the specific areas of study convinced us that many of the problems in the DI and SSI programs are interconnected. Our many hours of serious and intense deliberations led us to the conclusion that no single plan or solution will by itself solve these problems. Our identification and discussion of these problems reflect our common view that people with disabilities have the same rights and obligations with respect to work as the nondisabled.

People with disabilities should be encouraged to strive towards independence and away from dependence on disability benefits. Federal disability programs alone cannot ensure the general well-being of persons with disabilities. They are but one block in a unified structure, involving State, individual and private sector efforts.

For their part, the Federal disability programs, including programs of cash and medical assistance, should encourage work. The Council does not believe that the DI and SSI disability programs should function as programs of "premature retirement" or as "tickets out of the workforce." Instead, they should operate on the principle that many people with disabilities, if provided with timely and appropriate services, can work and should be encouraged to do so.

The Council believes that some fundamental features of the DI and SSI programs actually discourage people with disabilities from working because the goals and purposes of the programs have never been clearly defined. This confusion is most keenly felt by people with disabilities themselves. To qualify for benefits, they are obliged to prove that they are incapable of gainful employment. The process of establishing such a claim can be long and cumbersome. Such a process may be debilitating by itself because the person is certified disabled by the agency and labled incapable of work by all concerned. Once awarded benefits, they are told that regular and substantial earnings will cause their payments to stop, yet they also are referred for vocational rehabilitation (VR) services. Beneficiaries are thus sent mixed signals--they must prove that their impairments prevent them from working for at least 12 months in order to be awarded benefits; then they are encouraged to return to work and forfeit their benefits.

In looking at a solution for the problem, we identified at least three types of people with disabilities.

- o First, there are those who are totally impaired and permanently incapable of work (e.g., those who are terminally ill).
- o Second, there are those whose severe impairments will persist but who could become able to work, with the application of appropriate and timely VR services.
- o Third, there are those who are now able to work despite severe impairments.

The Council believes that SSA should respond differently to these groups.

- The first group clearly will never work. Thus, vocational rehabilitation services and work incentives have little relevance for them.

- The second group, those who perhaps could work if they enrolled in VR programs, should receive such services.

- The third group, the job-ready, require some incentives to move into the work force.

The Council believes strongly that SSA's disability programs should be restructured substantially over the long term so that the emphasis of these programs falls on moving people into the labor force rather than declaring them permanently unable to work from the outset. During our discussions of possible recommendations aimed at such a basic restructuring, we were frustrated by the lack of data which are essential to the creation of a new program and the formulation of sound policy. For this reason alone we refrained from developing recommendations that would fundamentally change the current programs. Instead, we recommend that SSA undertake demonstration projects that are comprehensive and that test a set of proposed changes. The agency should also sponsor research projects to examine various alternatives to the current DI and SSI programs.

VOCATIONAL REHABILITATION

The Council's examination of SSA's VR programs led us to conclude that these programs have a negligible impact on increasing the capacity of SSI and DI beneficiaries to work or return to work. Of particular concern to us is the fact that fewer than 15 percent of disability beneficiaries are referred to State VR agencies and that, in any given year, fewer than 1/2 of 1 percent of beneficiaries have their benefits terminated due to work activity. Thus, maximum savings to the trust funds and to the general revenues from the provision of VR services are not being realized. The Council believes that many beneficiaries who have the potential for gainful employment are not being enrolled in VR programs. As a result, they are being denied the means with which to improve the quality of their lives.

The Council recognizes that the Federal-State VR system is required by law to assign the highest priority to people with the most severe disabilities. We nevertheless believe that SSA should concentrate its efforts on identifying and referring to VR agencies those beneficiaries who have the greatest potential for engaging in gainful employment as a result of VR services. Such a policy will promote the major goal of SSA's VR programs, which is to place the maximum number of beneficiaries into gainful employment and, as a consequence, to achieve savings to the trust funds and to the general revenues.

The Council believes that there are several significant problems in the administration of SSA's VR programs which have undermined their effectiveness and we recommend changes to the referral, tracking and reimbursement procedures and provisions for better individual, State and private sector participation in VR programs. The problems and recommendations follow.

- SSA does not routinely gather experiential data upon which to validate its current VR referral criteria. It is essential that such data be gathered and analyzed in order to improve the cost-effectiveness of SSA's VR programs.

- SSA does not maintain any direct management control over its VR programs, save through the reimbursement process. We believe that it is imperative that SSA track persons referred by State Disability Determination Services (DDS) units for VR services in order to see if such services are actually requested or provided and to ensure that benefits are suspended to recipients who refuse to participate in VR programs without good cause. We also believe that SSA should evaluate either periodically or on an ongoing basis the quality and cost-effectiveness of the VR services provided.

- Differences in the goals of SSA's and the Federal-State VR programs must be recognized. State VR agencies wishing to be reimbursed by SSA for services rendered must assure that their VR programs for SSA clients that are referred by DDS units are geared towards the provision of those services that are necessary to achieve and maintain gainful employment. Further, DI and SSI applicants referred by DDS units to State VR agencies should be afforded the highest service priority by the Federal-State VR system.

- SSA's present system for VR referral and reimbursement promotes neither competition among service providers nor the involvement of employers and unions in the formulation of job goals, the identification of job requirements and job skills. SSA should promote active competition among public and private agencies and should involve employers and unions in the planning and delivery of VR services for DI and SSI beneficiaries.

Our review of VR programs was limited to the review of the effectiveness of SSA's VR programs for DI and SSI beneficiaries and of the criteria used to determine which applicants and beneficiaries should be referred for VR services. We did not look at the overall effectiveness of State VR programs. The Council urges SSA and the Rehabilitation Services Administration to work together to develop strategies for providing SSA clients with those services that will enable them to work. Only through such cooperation and coordination can SSA's VR goals of job placement and sustained employment be achieved.

WORK INCENTIVES AND DISINCENTIVES

In addition to SSA's VR programs, the Council also studied those provisions in current law that are intended to encourage DI and SSI beneficiaries to work. We believe that the work incentive provisions now in the law for DI beneficiaries, while they have not been broadly used, can be strengthened to provide real encouragement to work. This will require that they be clearly understood and marketed as an important part of the DI program, not just as technical details.

We also believe that the SSI program contains strong work incentives for beneficiaries who are blind or disabled through the provisions of Section 1619 and the plans for achieving self-support. The Council understands that SSA has undertaken a nationwide training and information program on Section 1619 and other work incentives, but urges SSA to employ intensive marketing techniques to further inform SSI beneficiaries, advocates and employers of all of the work incentive provisions in the law.

A number of witnesses who appeared before the Council expressed their support for extending a provision similar to Section 1619 to the DI program. However, after extensive study, we are not prepared to recommend that such a benefit offset be incorporated into the DI program. Although such a measure may encourage more beneficiaries to work, it also raises a number of concerns regarding equity and economic issues.

The Council understands that the fear of losing cash and medical benefits due to work attempts may be a key concern among beneficiaries and believes that this fear is in part attributable to lack of understanding of how entitlement to benefits are protected under current law. We recommend that SSA can best address this problem by improving public information and, where possible, clarifying the rules and regulations.

In addition, we recommend that the level of monthly earnings (more than $300) which currently constitutes substantial gainful activity (SGA) for workers with disabilities other than blindness is too low and should be raised. The Council also believes that the monthly earnings amount that counts toward the trial work period should be increased from $75 to the SGA level.

During our deliberations, the council members expressed concern over the preferential treatment in the DI and SSI programs for people who are blind compared to those with other disabilities, not only with respect to work incentives, but in other areas as well. We specifically recommend that steps be taken to eliminate the distinction between the SGA levels for those who are blind (more than $700) and those who are not.

As mentioned earlier, one of the Council's overarching concerns was the lack of data that are essential to the formulation of sound policy. Thus, we urge the Secretary to move expeditiously to implement the demonstration projects on work incentives authorized by the 1980 amendments. We believe that these projects should be of sufficient size and variety to yield fruitful results. As an adjunct to this, we recommend that SSA conduct a demonstration project to test incentives for individuals to participate in VR programs by waiving certain trial work provisions in the current law. Our other recommendations in the area of work incentives concern extending tax incentives and civil rights protection as possible means for assisting people with disabilities in their efforts to work.

While work incentives are important, the Council does not believe that financial incentives alone can ensure that all those who wish to work will be able to do so and that all those who have the capacity to work will choose to do so. Other important factors include family and community support, education, rehabilitation, job placement and employer and community attitudes, along with periodic reviews of continued eligibility. Not all, or even most, of these important factors can be influenced by the DI and SSI programs. An effective policy to promote work and return to work will require a concerted and coordinated approach involving government agencies and, most importantly, the knowledge and resources of the private sector.

DETERMINATION OF DISABILITY

Much of the Council deliberations focused on how disability is determined. The statutory definition of disability is intended to provide a single national standard for determining entitlement to disability benefits under both the DI and SSI programs. Although this standard is clear-cut, the Council is deeply concerned that there is an apparent lack of uniformity in the application of this standard across the States and at the various levels of appeal.

The Council believes that several significant problems in the structure and operation of both the initial disability eligibility determination process and the continuing disability review process currently prevent the attainment of an important program goal--to provide cash and related medical benefits to persons with severe disabilities without undue delay or expense.

Both the current variation among States in allowance rates and the volatility of allowance rates over time raise serious questions about the basic operational integrity and fairness of SSA's disability program. The Council believes that the allowance rates in these programs should not vary appreciably between States or over time, unless accounted for by differences in the number and characteristics of applicants.

The Council has three concerns about the disability decisionmaking and appeals process:

o The wide variation in State-by-State allowance rates;

o The high rate of appeal and reversal of SSA eligibility decisions; and

o The length of time involved in appealing SSA eligibility decisions.

Each of these implies a hardship for some applicants as well as unnecessary costs to applicants and the Government. The Council believes that the lack of uniformity in application of eligibility standards stems from:

o A lack of specificity in the rules used for determining disability;

o An inadequately controlled Federal-State arrangement for administering the DI and SSI programs; and

o A process which fails to encourage the development of complete and correct evidence early on.

We believe that SSA's overriding concern should be to achieve a higher degree of accuracy and nationwide uniformity in disability decisions and to ensure that accurate decisions are made as early in the process as is practicable. Although there was strong sentiment among some council members for federalizing the administration of the DI and SSI disability determination process, which is currently done by the State DDSs, we declined to make that recommendation in the hope of retaining the benefits of a decentralized administration. If this structure is to be retained, however, it must operate in a way that ensures that judgments about eligibility for disability benefits are appropriate and uniform.

The Council therefore made a series of recommendations that we believe will improve the accuracy and national uniformity of disability determinations. These recommendations include establishing more precise standards and criteria for determining eligibility for disability benefits, expediting the issuance of regulations that are binding at all levels of appeal, attempting to determine why DDS allowance rates vary and ensuring that review techniques focus on verifying the accuracy of decisions rather than verifying the accuracy of procedures followed.

The Council heard testimony that the capacity to work cannot be measured by medical factors alone. In view of this and the low termination rate due to medical recovery, we are concerned that the medical improvement review standard, which is used in the continuing disability review process, may not be the best way to measure whether or not someone can work. We are further concerned that the current medical improvement review standard places the burden of proof on the Administration rather than on the beneficiary and, therefore, may result in many people being "grandfathered" onto the disability rolls on a permanent basis when they may have actually become capable of work. In view of these concerns, we recommend that SSA study the medical improvement review standard.

USE OF MEDICAL SPECIALISTS IN THE DETERMINATION OF DISABILITY

Current law requires SSA to ensure that a psychologist or psychiatrist complete the medical portion of disability cases that involve mental impairments. After hearing testimony from advocates for people with disabilities, physicians, researchers and DDS employees, the Council believes that medical specialists are not routinely needed for review of disability claims that involve only physical impairments. Thus, we did not recommend that SSA be required to have medical specialists sign the determinations, whether favorable or unfavorable, in such cases.

However, we believe that SSA should continue to provide DDSs with policy guidelines and training in the appropriate use of medical specialists in the disability determination process. The DDSs, for their part, should continue to use specialist review when, in the judgment of the DDS disability/physician team, such review is warranted. In addition, we recommend that SSA monitor the use of medical specialists by DDSs to ensure that they are used when appropriate; that SSA make suitable arrangements with medical schools or medical centers when specialists are necessary, but unavailable; and that SSA encourage, through direct funding, the improved capability of physician specialists in the area of disability determination.

USE OF WORK EVALUATIONS IN THE DETERMINATION OF DISABILITY

Based on testimony that the Council received from one State's interagency task force, DDS examiners and SSA, the Council believes that work evaluations often provide additional information that is useful in the disability determination process and urges SSA to monitor their use by DDSs. However, the Council does not believe that the use of work evaluations needs to be mandated. Rather, DDS personnel should be properly trained regarding when to obtain work evaluations and SSA should ensure that work evaluations are obtained when such information would be of assistance to the disability determination process.

We also recommend that SSA and the State VR agencies share results of work evaluations. This will not only to avoid duplication but, more importantly, will ensure that all available evidence is considered during the disability determination or VR evaluation process.

CONCLUSION

The Council believes that it has taken a comprehensive look at all aspects of SSA's disability programs and has made a number of recommendations which, in both the short and long term, will improve the administration of these programs. We strongly believe that a national disability program must encourage work and serve as a catalyst for changing attitudes on how the nation views disability and the productiveness of all of its citizens. We offer our recommendations as SSA's disability program nears its thirty-fifth year in hopes that as the program approaches the next century it will be better able to assist those who are disabled realize their full potential.

This concludes my testimony. I will be happy to answer any questions that you may have concerning the Disability Advisory

Chairman **Jacobs**. Mr. Affeldt, would you care to say a word or two about the disparity between the SGA measure for the blind on the one hand and other disabled on the other?

Dr. **Affeldt**. Yes. There was testimony brought forth to our Council meetings to the effect there was a significant difference, two times at least the difference, in terms of the benefits to the blind under the disability provisions. The Council looked at this and could not find an adequate reason for the disparity in terms of one disability group versus another group and felt there was an inequity here.

Therefore, they did deal with that question, and they do have a recommendation concerning it, but it does go back basically to the recognition of an inequity and an inability to find a reason for that.

Chairman **Jacobs**. Thank you, sir. I think your testimony is complete, and the committee expresses its gratitude and the committee also will recess for about 8 minutes. Thank you.

[Recess.]

Chairman **Jacobs**. The committee will resume its sitting, and our next witness is the Honorable Steve Bartlett, our colleague from Texas. Mr. Bartlett, you are very welcome to the subcommittee.

STATEMENT OF HON. STEVE BARTLETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. **Bartlett**. Thank you, Mr. Chairman.

Mr. Chairman, I will have written testimony to enter into the record. I am here to testify today on legislation I introduced yesterday together with Congressmen Levin, Matsui, Gradison, Lagomarsino, and Wortley. It is legislation that—along with those individuals and yourself, Mr. Chairman, and others—I have been working on for some time.

Mr. Chairman, the legislation is entitled the "Social Security Work Incentives Act of 1988." It is the follow-on to the 1619 program for SSI, and particularly the legislation of Public Law 99-643 that was enacted by Congress 18 months ago entitled the "Employment Opportunities for Disabled Americans Act."

This law that had been enacted eliminates work disincentives for SSI recipients who want to accept a job and who would by accepting that job be in danger of losing their health benefits. It was through this subcommittee and the full committee that this law was enacted.

First a little bit about the 1619 program. Data from the Social Security Administration shows that this law is having a rather dramatic effect so far. In December of 1987, the number of participants in 1619 totaled 30,191; 14,459 of those in 1619(a) receive both cash benefits and Medicaid, and the balance, some 15,000 are in 1619(b). That is the largest number of participants to date since July of 1987 when the law took effect. Participation in 1619(a), which are those persons receiving Medicaid because they were earning—because their earnings are sufficiently high, Medicaid only, 1619(a) is increased by 1,014 percent from July through December—I am sorry, that is the portion with the 1619(a), those receiving cash benefits and Medicaid, their earnings are low; 1619(b), those persons receiving Medicaid only, has increased 25 percent just in those 6 months.

The 1619 program and Public Law 99-643 then only goes half way. It is not enough. It only applies work incentives to persons who are on SSI but not to SSDI. The purpose of the legislation that I introduced yesterday is to extend that incentive to persons who participate in the SSDI program. In 1987, 2.8 million disabled workers received SSDI benefits. Approximately 33 percent of the disabled worker beneficiaries in SSDI were under the age of 45. We will hear testimony, and it is in the Commission's report, that statistically the average of that group tends to be older, over the age of 50, and that is true, but individuals don't work with averages, individuals are individuals. Thirty-three percent of that group are under the age of 45. That is the age group primarily who are in their prime working years who could and want to substantially contribute to our economy and to their own independence if they could return to work without fear of losing health benefits.

Now, Mr. Chairman, to sum it up in terms of what the focus of the bill is today if you are on, to oversimplify it, but today if you are on SSDI at any age and you want to return to work, you are faced with this dilemma. If you are on SSDI and disabled, if you have that disability and you stay unemployed, you receive Medicare, the assurance of some kind of health insurance.

On the other hand, if you have the same disability and you are offered a job and you choose to go back to work, you lose Medicare and you also may or may not receive private health insurance and, thus, the dilemma. Further than that, you may have some difficulty being reinstated into Medicare and depending on your disability, your disability may cause you to go in or out of your system or in or out of your participation in work. And, thus, a recipient is simply faced with the difficulty if you are disabled and unemployed, you get health insurance; and if you are disabled and employed, you may or may not.

As I have interviewed a large number of persons on SSDI, as well as SSI, in developing this legislation, those individuals tell me that it is that loss—that fear of a loss of Medicare and not a replacement with health insurance that is their single greatest impediment in going back to work. I do have to comment at this point, private health insurance is oftentimes available to those individuals who go back to work and often times not. There is a great deal of uncertainty. Even when it is available, it is too often with particular disabilities available with an exclusion of a preexisting condition, and with some kinds of disabilities that preexisting condition tends to cover everything.

A classic example is a disability entitled multiple sclerosis. It is a disability, it is recognized by SSDI as a disability, thus if you have MS and you go through all the traps and you prove you can't work, you are entitled to SSDI. So far so good. But the world has changed, and if you can continue to work, and many people do and want to, but the difficulty is when you then go back to work with MS, even if you do obtain private health insurance, any kind of an accident or an illness, private health insurance will often count toward your MS. They say that is a preexisting condition. If you have a broken leg, it was because of MS. If you develop pneumonia, it was because of MS, whether indeed it was or wasn't. Nevertheless, you don't find out until it is too late.

What we have created is, we have attempted to remove that disincentive by creating a new category of disability which is much more in tune with modern technology and modern systems in the work place entitled "Disabled and Working." Perhaps there was a time in our society, and I believe that there was, in which our definition of disability was accurate, disability means you can't work. That is not accurate any more. That is not the way the real world works, but that is still the way that our disability laws work. Our disability laws in SSDI say disabled means you can't work, and, thus, we have the difficulty in the definition.

So what the bill does, it allows someone to go back—an SSDI recipient to go back to work, earn above the substantial gainful employment level, which is currently set at $300 a month, and be placed into a disabled and working category. What that means is two things, first of all, in this category. First of all, you would receive a cash offset beginning at $85 a month of earnings. You would have an offset of $1 for every $2 of earnings that you received, you would have a cash offset of $1 of every benefit, as many other programs do, you then begin to phase out your cash benefits. That is both a savings to the Government, and it is also a savings or an incentive to the individual who is going back to work, to say nothing of the economy. Everybody wins.

Second, we deal with Medicare as follows: It seems to me the real disincentive while working, a major disincentive is the sudden loss of cash benefits of $300 a month. An even more significant disincentive is the loss of Medicare. If you become employed and earn over $300 a month, you lose your Medicare and you may not have it replaced by private health insurance.

So what we have developed under this program is parallel to 1619. Under 1619, SSI recipients continue to receive Medicaid upon returning to work. SSDI participants, the same disabilities in similar circumstances cannot do that after a cumulative of 48 months of work. SSDI recipients don't have access to Medicaid coverage, but they are instead covered by Medicare.

We have provided then two things, first of all, to retain the current 48-month cumulative. In current law a person receives a 9-month trial work period which, according to the Disability Commission report and all other sources, is terribly confusing and is not doing what it was intended to do. During that 9-month trial work period, the person then continues to receive all their Medicare benefits at work. It sounds good.

The problem with it is that many people with many disabilities will try a work period for 2 or 3 months, it doesn't work out, so they go back to being unemployed again, and they try again a year or so later, and it doesn't work out. The 9 months is a lifetime 9 months, it is not a continuous 9 months. The difficulty is that 9 months itself has become an impediment. Followed on in that current law is an additional 36 months of extended coverage in which you can receive Medicare, with no cash benefits. That is a total of 48 months.

This bill collapses those programs into one in which we say from the time you enter this program, earn your first $85 a month, then for the first 48 months you are entitled, as you are entitled under current law, so there is no additional cost to a total of 48 months of Medicare coverage, no change for the Government because you are entitled to that.

By the end of that 48 months, and by the way, that is a lifetime cumulative, which is what makes it difficult, at the end of 48 months, we would permit an SSDI beneficiary under this disabled and working category to buy into Medicare at the conclusion of 48 months, thus eliminating their uncertainty as to whether they will be able to have health insurance.

For a person who is earning below 150 percent of the poverty level, which is currently $8,655, we would have Medicaid, the State Medicaid plan, pay the premium for Medicare. That is what Medicaid is set up for, and that is to provide health insurance for lower income people. Those between 150 and 300 percent of the poverty level, or $8,600 to $17,000, we would have the State Medicaid plan pay a declining portion of that premium with the worker himself or herself paying the balance, and over 300 percent, we would just simply say the individual can buy into Medicare if they choose to, if they are having difficulty getting insurance somewhere else or if they have a preexisting condition, they can purchase it.

Now that is expensive, but disabled workers who are working are not so concerned about the expense as the ability to be certain they have Medicare. We put an additional provision in the bill, and that is we have said that the private health insurance, a group policy someone is on, would be the payer of first resort and not the payer of last resort.

And, frankly, that needs to be in there to provide that both employers and health insurance programs and workers don't use this as a loophole or a way to drain the system.

We also provide for automatic reinstatement for those individuals whose incomes fluctuate, and there are types of individuals, particularly mental illness, in which this would apply. We would allow an individual who is working and receiving disability benefits on the date of enactment to be grandfathered or not subject to these new rules if their income doesn't exceed $250.

Frankly, we are looking for new workers. There are some workers in which if their income is $150 to $250 and has been for some time, they would receive a slightly lower cash benefit under this program, and so we are grandfathering those current workers.

We are also allowing individuals to retain their SSI eligibility for Medicaid even though they receive SSDI benefits. That is a loophole that has needed to be closed for some time that I put into this bill, even though it is a little bit different from the focus of it.

There are individuals who are disabled and receiving SSI eligibility. Upon the death or retirement of their parents, they become eligible for SSDI and SSDI has a higher cash benefit so the law assumed they would always want to step in and receive SSDI as a result.

It is not always so because SSI has currently a 1619 provision which does permit you to go ahead and continue to receive Medicaid. We are simply making that SSI eligibility at the person's option as opposed to now when they move into SSDI through no fault of their own, through their parent's death, then they lose their SSI eligibility.

Having not yet received a cost estimate from CBO, I will be negotiating and working with both CBO and the members of this committee and with Social Security to obtain a cost estimate and to refine that cost estimate so that we calculate the net cost or the net savings of this bill.

If this legislation is looked on as a static piece of legislation in which the same number of people would be working after this is in effect as before, that will essentially allow CBO and Social Security to calculate the gross cost of it, meaning to multiply the cost of the additional Medicare, what they would view as additional Medicare coverage to people that are working, under current law, wouldn't be paying. That is not an accurate reflection of the cost and I am hopeful CBO will not measure it that way.

It is not accurate because this bill has no impact at all except for the individual who used to not work and thus was paying cash benefits and Medicaid and now chooses to work, in which case was paying either at least fewer and in many cases no cash benefits, and at least fewer and in many cases less Medicare.

So in the essence of just tracking who it affects, it only affects people who used to not work and are working and would work under this. There is only a savings for those individuals.

There are no additional costs for someone in that the Government is not paying any more than they would have paid had the person not been working and in fact the Government is paying substantially less, so it is a win, win, win piece of legislation.

The individual wins because they are able to go to work, support themselves, provide for additional independence; Medicare wins because they are paying no more than the current beneficiaries that they were paying before and in many cases fewer, and they have bought private health insurance into it on a voluntary basis and thus the taxpayers win with lessening of both tax benefits and Medicare costs, and the economy wins, because as we move into the 1990's, this economy is in desperate need of trained, thoughtful, productive workers and this is a category of some 2.8 million workers of current SSDI benefits that can be of substantially more benefit to the economy through working than they are through not working.

I will be happy to answer any questions about the legislation.

[The prepared statement follows:]

TESTIMONY BY CONGRESSMAN STEVE BARTLETT

BEFORE THE SUBCOMMITTEE ON SOCIAL SECURITY

MAY 26, 1988

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to testify before the Subcommittee today on the Social Security Work Incentives Act of 1988. I introduced this bill yesterday with my colleagues, Congressman Levin, Congressman Matsui, Congressman Gradison, Congressman Lagomarsino, and Congressman Wortley.

STATUS OF PARTICIPATION IN THE 1619 PROGRAM

Eighteen months ago Congress enacted Public Law 99-643, the Employment Opportunities for Disabled Americans Act. This law eliminates work disincentives for SSI recipients who want to accept a job without losing their health care benefits. It was through the support and hard work of this Subcommittee that P.L. 99-643 was enacted.

Data from the Social Security Administration shows that this law is having its intended effect. In December, 1987, the number of participants in the section 1619 program totaled 30,191 -- 14,559 in section 1619(a) (those receiving cash benefits and Medicaid) and 15,632 in section 1619(b) (those receiving Medicaid coverage only). This is the largest number of participants in this program to date. Since July, 1987 when P.L. 99-643 took effect, participation in section 1619(a) has increased by 1,014 percent through December, 1987. Participation in section 1619(b) has increased 25 percent from July to December, 1987. Passage of this legislation has provided work incentives for the disabled.

NEED FOR PARALLEL PROGRAM IN SSDI

But P.L. 99-643 is not enough. It only applies to persons with disabilities who participate in the SSI program. This work incentive should be extended to persons who participate in the SSDI program. In 1987, 2.8 million disabled workers received SSDI benefits. Approximately 33 percent of the disabled worker beneficiaries allowed benefits in 1987 were under age 45. This age group, in their prime work years, could contribute substantially to our economy and to their own independence if they could return to work without fear of losing their health benefits.

FOCUS OF BILL

H.R. 4680 removes an essential disincentive to work by allowing SSDI recipients who do return to work and earn above the SGA level ($300 per month) to be considered "disabled but working." When an SSDI recipient returns to work, regardless of whether his earnings would place him in the "disabled but working" status, his monthly benefit will be reduced by one dollar for every two dollars earned, after exclusion of the first $85.00 and impairment-related work expenses. The person will be permitted to stay in the "disabled but working" status as long as he continues to have the disabling impairment that is the basis of his eligibility. This is parallel to Section 1619 in the SSI program.

MEDICARE BUY-IN PROVISIONS

The real disincentive to working, though, is a loss of medical benefits rather than cash benefits. Under the 1619 program, the SSI recipient continues to receive Medicaid upon returning to work, but SSDI participants in similar circumstances cannot receive Medicare after a cumulative employment of 48 months.

SSDI recipients do not have access to Medicaid coverage, but are instead covered, after a two-year waiting period, by Medicare. H.R.4680 does not change that provision. Under current law, SSDI recipients who return to work are covered by Medicare for 48 months and are then shut off. This legislation will allow SSDI recipients in the "disabled but working" status to continue to receive Medicare benefits for 48 months and be able to buy into Medicare once the 48-month period is exhausted.

There are three parts to the buy-in arrangement which include:

> The State Medicaid Plan would pay the Medicare premium for individuals with earnings below 150 percent of the poverty line ($8,655) and individuals who meet the SSI resource test.
>
> The State Medicaid Plan would pay a portion of the Medicare premium and the individual would pay the rest if the individual's earnings are between 150% and 300% of the poverty line ($8,655 to $17,310).
>
> Individuals whose earnings are above 300% of the poverty line would pay the entire Medicare premium.

OTHER PROVISIONS IN THE BILL

Other provisions of the legislation would: (1) provide for automatic reinstatement for those individuals whose income fluctuates, (2) allow an individual who is working and receiving disability benefits on the date of enactment not to be subject to these rules if his income does not exceed $250, (3) and allow individuals to retain SSI eligibility for Medicaid even though they receive SSDI benefits based on their parents' retirement, disability, or death.

COST

While I have not yet received a cost estimate from CBO, I believe the bill will generate savings to the Disability Insurance Trust Fund through reduced benefit payments. The concept is basic: this program has no operational effect at all unless the recipient goes to work. If the person goes to work, SSDI's cost of cash benefits and Medicare benefits declines. In addition, there will be increases in federal income taxes and revenues will increase in the OASDI and HI Trust Funds from income and employment taxes as well. The legislation will reduce any Medicare costs because it requires employers to cover their disabled workers under their employment-based health plan with Medicare as the secondary payor.

NEED FOR CHANGE

When the SSDI program was created, it was based upon the policy that a person with a disability could not work. But times have changed and today, through technology and training, people with disabilities can and want to work. They should have that opportunity. Unfortunately, our laws affecting federal benefit programs have not kept up with these changes. H.R. 4680 does not change the current system to qualify for SSDI benefits, but it does provide the SSDI recipient the opportunity to work and perhaps get off the federal rolls.

I have discussed this legislation with Commissioner Hardy and I want to work with her and the Subcommittee as this bill goes through the legislative process. One of her concerns with H.R. 4680 is that it continues to provide cash benefits to SSDI recipients who return to work. However, the Congress made this public policy decision in the SSI Section 1619 program and the same definition of disability is used to qualify for both programs. The alternative is that SSDI recipients will stay on the disability rolls receiving full cash and Medicare benefits for the rest of their lives.

Only one-half of one percent of these workers ever return to the workforce. Many SSDI recipients are in their prime working years and want to try and go back to work. But the potential loss of Medicare after 48 months is a tremendous disincentive. If this legislation can double the percent of SSDI recipients returning to work, it will be a tremendous success.

I urge my colleagues to cosponsor this legislation. It will promote employment among persons with disabilities by removing a major disincentive which currently exists in the SSDI program, and provide people with disabilities the security they need to accept a job and lead independent lives.

Thank you.

Chairman **Jacobs**. Mr. Levin.

Mr. **Levin**. Thanks for your analytical examination of this.

Like all legislation, even good legislation, on its face, there is work to be done—I am sure you would acknowledge that. We are looking forward to pitching in and helping as much as we can, at least I am.

One of the questions that remains to be explored further is the Medicare-Medicaid interplay here. One of the questions that has been raised is why use the Medicaid buy-in system at all?

As I understand it, CBO, when they look at the cost estimate, is examining what the alternative costs would be; is that correct?

Mr. **Bartlett**. Yes.

Mr. **Levin**. I think someone is here from CBO, right? I would hope that they could accelerate that effort.

Let me ask you, you have been working on this for some time; several of us have also been working on it for a much shorter period. I missed the earlier testimony, Mr. Chairman. I'm sorry I wasn't here.

Chairman **Jacobs**. You can be forgiven.

Mr. **Levin**. I understand some questions were raised about the impact on higher income recipients, those who would be receiving higher income. What do you think is the major argument against this bill? That is one that was put forth this morning.

If you took the other side from all that you know of this, what do you think is the biggest negative?

Mr. **Bartlett**. Well, the largest negative is simply in the way one looks at the world. I don't believe it is a negative, but the opposition will come from a static view of these individuals.

The opposition will come from an assumption that somehow these individuals, of which only one-half of 1 percent of SSDI individuals are returning to work, the opposition would come from somehow those one-half, we are paying something extra to those one-half of 1 percent.

I don't believe we are, but even if we were, in order to pay something extra to that one-half of 1 percent, in order to double it or triple it or cause some kind of revolution would be 5 percent of SSDI beneficiaries returning to work, then that is, well, that savings overshadows the cost. So the opposition comes from a static view of looking at it, by and large.

I urge the subcommittee, as all of the estimates are made and the cost estimates, to always ponder the question that—to reduce it back to that individual and what would have been the cost to the Government if that individual whom CBO and Social Security may calculate we are now spending money on through Medicare and cash benefits after they go back to work, what would be the cost to the Government if that individual had not gone back to work and indeed that individual is 99 percent likely not to go back to work and the cost would be higher?

So in essence, if this doesn't work at all and if no one goes back to work as a result of it, then the Government is basically out no cost with the exception of that one-half of 1 percent. And if people then use this to go back to work, then the Government still will continue to pay some benefits, which we hadn't done in the past, but those benefits that we are paying out would be less than what we would have paid out had they not gone back to work.

One of the criticisms that has come up has been exactly that. Who pays for the Medicare buy-in? There is a middle group here who, on the surface of it, could not upon going back to work, it would be too much of a disincentive for them to go back to work if we required someone earning $8,000 a year, say, to pay their own Medicare, so I concluded we ought to provide a phase-in of between, based on a poverty level, so that anyone earning below 150 percent of poverty, State Medicaid would pay itself.

If someone is earning $4,000 a year and we require them to pay $2,400 a year in a Medicare buy-in, it is unlikely they are going to go back to work and pay half their wages in Medicare.

So somehow we have to cover that group. I propose that we use that transition with Medicaid. It is only a transition up to current levels up to $17,000 a year on a phased buy-in and have Medicaid pay it. The committee may want to adjust that transition, and that is fine.

After the person, though, is earning $17,000 a year, then they have to buy their own Medicare and that seems to me therefore, on the face of it, we are not paying Medicare benefits, paying for Medicare benefits to high-income individuals, we are shutting it off at 300 percent of poverty.

Now, the other two options are to have the General Treasury pay for the Medicare premium. Many of the retirement types of groups are opposed as a camel's nose kind of theory to means testing Medicare. Medicaid is already means tested, so we moved over into there.

The other way to do it would be simply to have no phase-in at all and have Medicare be available indefinitely for SSDI recipients so long as they have the disability. It seems to me that is both unnecessary and too costly.

The other option would be the committee could collapse that phase-in or that buy-in and thus reduce the cost somewhat on that.

Now, the cash benefits, we have a one-for-two offset or reduction. Perhaps the committee can come up with a better way to do that. Current law essentially has a cliff at $300 a month. Once you earn $300 a month for more than 9 months lifetime, you are ineligible for cash benefits.

Now, disabled individuals can figure that out pretty well. They figure out therefore they are not going to earn more than $300 a month over a lifetime of 9 months, more than 9 months over their lifetime, and that is essentially the difficulty that we have now, is we can put that limit or cap on people at 300 bucks a month, provided for the offset, then, beginning at $85 a month for the transition.

I don't know of a better way to provide the offset. There will be a proposal which the committee could think about to cap off that offset at some arbitrary figure to say at $18,000 or $20,000 a year or something like that, then you would have the sudden cliff or immediate loss of all cash benefits.

Philosophically, you could make an argument to do that. You then run into, though, the same problem with those who would resist means testing SSDI because, remember, SSDI is an insurance program people have paid into to receive insurance and to cap it off in some arbitrary way ruffles the feathers on that side.

Mr. **Levin**. Thank you. I look forward to working with you. I think we have learned from efforts in other fields it is worth looking for creative, instructive, positive linkages between a benefit system and work. If it is anything punitive, I think we shouldn't touch it. I think it is in everybody's interests to see where relative linkages might lie, and your bill, I think, gives us an opportunity to look for those creative linkages.

Thank you, Mr. Chairman.

I yield to Mr. Daub.

Mr. **Daub**. I thank the gentleman for yielding.

Do you want to say what you understand? I am on the edge of the cliff right now.

Mr. **Bartlett**. The current system doesn't work. The status quo works to cause 99.5 percent of SSDI recipients not to go back to work.

As you return home to your districts, if you find an SSDI recipient, ask them why they don't go back to work. They will tell you it is the sudden cliff and the loss of Medicare or being unable to reinstate it.

Mr. **Levin**. That is true in some cases. No one knows the universe. We are talking about two-point-some million individuals. The situation will differ, obviously, from person to person. Your notion is for some significant number this barrier is a negative rather than positive condition.

Mr. **Bartlett**. For a significant number of that 2.8 million, it is the most significant barrier, and it is a barrier that, with some creative legislation, we can improve.

Chairman **Jacobs**. Let the record show Mr. Daub——

Mr. **Daub**. Will the gentleman continue to yield?

Mr. **Levin**. I am surrendering.

Mr. **Daub**. Mr. Chairman, thank you. I commend you for the hearings today. I am delighted to be here. I am sorry I was late and didn't get to hear the first witness.

Last spring at our hearing, you might remember, I talked about staffing levels and the management of Social Security and I spoke about that demographic change in the workplace that our witness just alluded to. We are going to be anxious to find every way we can to put productive people to work. We will have a distinctive, massive labor shortage relative to the workplace for the first time in our history. That means we ought to be looking at ideas, like those of the gentleman from Texas and those who are cosponsoring his innovative legislation.

I want to thank you for the time you have taken to work on a very complex, and not very sexy, from a political point of view, kind of labor. It is going to be appreciated by many including many of us on the subcommittee, those of us who are interested as well, seriously interested, in working to solve some of these problems.

You testified, did you not, before the Disability Advisory Council?

Mr. **Bartlett**. I did.

Mr. **Daub**. Some of the concerns raised were that the program you offer as you liberalize it or make it more flexible or modernize it might invite many who are not currently on the disability rolls to seek to become entitled. What would you say to that?

Mr. BARTLETT. I would say that that is an unfounded fear, but some on the Advisory Council concluded that somehow by having a work incentive program of allowing people to go back to work after they have been disabled and unemployed, it would cause people to become unemployed in the first place in order to wait 2 years to get Medicare. The reason they wouldn't do that is, first of all, if you are working and you quit your job and become unemployed, you wouldn't do it deliberately to get SSDI because you get less money, you have to wait 2 years for the waiting period for Medicare, which I have not changed in here, and you may or may not be entitled to disability. You don't know until you go through all the disability review processes.

So you create additional uncertainty for your life. You have to wait 2 years for Medicare. At the end of that 2 years, you then apply for this program and really all you have benefited yourself is the ability to go back to work.

So it seems to me that while one could make a case there may be some rare individual who would choose to go to all that effort to gain the system in order to obtain health insurance that they already had, it seems to me to be somewhat——

Mr. DAUB. I would tend to agree with you unless we pass a long-term health bill which contains, at page 16 of the print, the remedy that those disabled individuals may actually buy-in during their 24-month waiting period for Medicare, or receive insurance coverage at what the Secretary senses is the actual cost of that program.

In other words, if the program were the same as it is now, I would tend to buy your argument. But, I want to raise for your consideration as you pursue and as the committee pursues this idea, that we may be making it attractive to go on to a more liberal disability program, if in fact under the Pepper bill we are going to let people buy-in for coverage during the 24-month waiting period.

Now, the difference, of course, is that under part B it is 75 percent Federal funds and 25 percent to the beneficiary, and under this particular formula we are suggesting in the Pepper bill, the cost would be 100 percent of that benefit to that person who is disabled who would like to have that insurance coverage in the interim or gap you are talking about.

Take that into account in the argument that you are making. Perhaps it wasn't considered during debate and dialog.

Mr. BARTLETT. Or someone could do that now.

Mr. DAUB. They could.

Mr. BARTLETT. Without the ability to go back to work, someone could still quit their job and apply for disability today.

Mr. DAUB. Sure.

Mr. BARTLETT. And get all the benefits, no more benefits than this entitles them to.

Mr. DAUB. I agree. What about the costs? Have you looked at their estimate of your 75-year cost of $2.3 billion? Do you have any comments you want to make?

Mr. BARTLETT. I don't think they are accurate. I think it was strictly a static analysis. I will tell you when this committee passed out the SSI bill, 1619, to do this same thing for other disabled persons who are on SSI, the first cost estimates are always these large, static estimates that forget the only persons this affects are people who used to work and are not working. That is a cost savings.

I think a less-than-static estimate will produce a net savings instead of a net cost.

Mr. DAUB. Your bill, the Social Security Work Incentive Act of 1988 represents a significant departure from past practices. Isn't the payment of disability benefit based on the premise of total disability contradicted by the idea someone can be disabled and working?

Mr. BARTLETT. What is contradictory is current law contradicts the current society. Perhaps there was a time in which if you were disabled that meant you couldn't work, but that doesn't mean that anymore. It means that you can work.

Societies change, medical technology has changed, the workplace has changed, the nature of disabilities have changed and people who have disabilities now can and want to work, but our laws haven't changed. Our laws, and I wish I could have proposed to you a bill that would have fixed the basic definition of disability, but I wasn't—we are not quite there on a consensus yet. But the basic SSDI and SSI law says, defines disabled as being unable to work. That is an antiquated definition.

So rather than try to change that definition, I just created a new and more realistic and modern category of disabled. You have multiple sclerosis, you have chronic schizophrenia, you have other disabling conditions which are very disabling, but you can still work and hold a job in modern society.

When these laws were written, that wasn't true, but it is true today and this moves us forward.

Mr. DAUB. Let me ask about the cliff you talked about. What about people in sheltered workshops; maybe they work for more than $85 but less than $300?

Mr. BARTLETT. Well, the current law tends to keep those people in sheltered workshops, which is better than not working at all, but I want to tell you it is, it can for individuals become a trap.

Mr. DAUB. Would your bill reduce their overall package?

Mr. BARTLETT. No, we grandfather anyone who is already there. A new entrant to a sheltered workshop, what we are saying is modern disability, our understanding of modern disabilities is that sheltered workshops should be for most people, not all, but many people a transition into competitive employment, and if you put the $300 cliff for new entrants, if you put a $300 cliff that says if you earn over $300 a month, which means, translated in the real world, if you leave your sheltered workshop, you are going to lose your Medicare. Guess what you never lose? Your sheltered workshop.

The bill itself does grandfather those persons who are already in that category to allow them to continue to stay in a sheltered workshop or receive less than $300 a month under the old benefit package.

Mr. DAUB. Let me make my last comment.

I think we are fast approaching the point where when you look at the aging demographic, fewer births, fewer deaths, and the wellness commitment we as individuals and we as a society are making, that lifeline, demographic problem is that we are going to have an explosion on the Social Security rolls.

We all know it. It will go from 32 to 54 million by the year 2011. You put the AIDS factor into it, add the medical costs of that to the medical trust funds.

Start to look at fewer workers paying for a lot of benefits established and yet to come on that demographic population shift, and I believe this kind of an enlightened approach is necessary, but I think it has to be income related. It has to be means tested.

We ought to be looking seriously at income relating and means testing, all of these kinds of programs. Simply change the definition to paycheck related.

In other words, look a little more if you would at your own legislation and not worry about a cliff so much. I like what I heard you say about your bill. There is an income-related process.

Maybe just relate it to the paycheck over 48 months. Take a look at the paycheck and make some reporting requirements for the individual so that as the paycheck does improve—not assets at home, the value of the house, the money saved in a savings account, or other things that tend to be evaluated in the traditional sense of welfare—look at the paycheck itself as a way of gauging whether that person should get less and less opportunity to participate in the Federal transfer program that is offered.

It is a way of looking at it that does not connote some of the old stereotypes. One can have the dignity of participating in the work place on his own, instead of whether or not he is below some poverty line, some threshold, today you had a benefit, tomorrow you have nothing.

Mr. **Bartlett**. I don't disagree with you here. I am proposing a revolution, you are proposing a cataclysm. This bill is a modest revolution designed to not take away any benefits that are currently offered.

That is why we kept the 48-month time frame in there and not—but that are currently offered to an individual beneficiary. All the benefit package stayed the same, and all we say is that as you go to work, then your work earnings, you can begin to work your way out of the benefits.

So we haven't added benefits.

Mr. **Daub**. Do we need a demonstration project for this?

Mr. **Bartlett**. If we were unable to pass this legislation out this year, I think it would be helpful to have a demonstration project designed, something like this, to prove it.

Remember, we had a demonstration of 1619 before we got that permanently into law. It was so effective that the pressure built up to make it permanently authorized and streamlined.

That is when it started to take off.

Mr. **Daub**. Mr. Chairman, I would like to offer my formal statement for the record.

[The statements of Mr. Daub, Mr. Archer, and Mr. Crane follow:]

Statement of the Honorable Hal Daub
May 26, 1988

Mr. Chairman, last spring as I'm sure you remember, we had a hearing about staffing levels and the management of the Social Security Administration. At that time I spoke on the demographics of the workplace -- the fact that SSA couldn't continue to replace workers on a body-for-body basis, even if it wanted to. The number of new workers entering the workforce will continue to decline, causing employers to compete for employees.

That competition for employees is, I predict, good news for the disability program. As the Disability Advisory Council notes, the number of disability claims generally rises during economic downturns. One can readily conclude that the availability of employment has a significant impact on initial claims. What we need to do is to ensure that this coming need for productive workers is an equally effective inducement to transfer some of those on the disability rolls back to gainful employment.

To do that we need to streamline the vocational rehabilitation process, and ensure that incentives exist to encourage both beneficiaries and employers to take a chance.

I want to compliment the Disability Advisory Council and the GAO for the thoroughness of their reports. It is clear that the current VR process isn't working as intended. As the Council reported, a finding of disability shouldn't translate into "tickets out of the workforce" for everyone. Those who can work -- if provided timely and appropriate services -- should be encouraged to do so.

That recommendation highlights another aspect of the GAO report I found disturbing: a GAO survey of 10 states which determined that over half of the beneficiaries actually contacted by state VR agencies either failed to respond or declined services. Yet, the law provides that, absent good cause, benefits will be suspended in those cases! One has to question how well that statute is being enforced.

GAO reports that the VR counselors dismiss those uncooperative beneficiaries on the main grounds that with that attitude they wouldn't make good VR candidates. That supports the Advisory Council's recommendations for an accelerated referral, with far better interaction with the applicant/beneficiary, and much stronger management controls. It also supports a recommendation that alternative VR services be explored.

In conclusion, I want to commend the Advisory Council for taking a broad view of the disability program and its interaction with other federal programs. I hope other Committees in the Congress will invite you to testify, or consider your recommendations.

Mr. Chairman, I want to thank all of today's witnesses for appearing before us today.

STATEMENT OF THE HONORABLE BILL ARCHER
MAY 26, 1988

Mr. Chairman, I am looking forward to today's hearing. I know that the Disability Advisory Council has, at our request, "labored in the vineyards" for over a year, analyzing the social security disability program. In my opinion, the nature of work incentives, and the effectiveness of vocational rehabilitation are of critical importance. I fully agree with the Advisory Council that:

> ". . . people with disabilities have the same rights and obligations with respect to work as the nondisabled have. People with disabilities should be encouraged to work, and should cooperate in services designed to enhance their work capacity."

In that context, the December 1987 GAO report, also on our agenda, is most discouraging. Only 0.3% of 1983 beneficiaries left the disability rolls after being successfully served by a vocational rehabilitation agency. Mr. Chairman, surely we can improve on that?

I want to welcome my colleague from Texas, Steve Bartlett. His new bill, the "Social Security Work Incentives Act of 1988" would introduce a quite different work incentive approach. I look forward to his testimony.

I also want to take this opportunity to promote my bill, H.R. 2117, the "Social Security Procedural Improvements Act of 1987", which seeks to improve the disability claims process. The Advisory Council report touched on one of its three major provisions, federalization of the state agencies. H.R. 2117 would permit federalization at the discretion of the Secretary to assure the effective, equitable, and uniform administration of the program. Given the Council's concern about the lack of uniformity in the adjudication of disability claims, I am surprised that federalization wasn't recommended. I look forward to a discussion of this issue.

Mr. Chairman, I want to thank all of today's witnesses who have taken the time to appear before us today. I appreciate their concern about the disability program, and the disabled persons whom that program protects. Particularly in view of the "medical improvement" standard enacted four years ago--which will leave some borderline cases on the rolls--I think it is important that we reevaluate ways in which some otherwise eligible beneficiaries may be helped to return to gainful employment. I'm convinced that both those beneficiaries and the national economy would gain.

STATEMENT OF THE HONORABLE PHIL CRANE
May 26, 1988

Mr. Chairman, I want to express our appreciation to the members of the Disability Advisory Council for their contribution to the Social Security disability program. I found their report comprehensive and thought provoking.

I am in full agreement with their observation that the federal government:

> "cannot alone ensure the general well-being of all its citizens. The primary role of families, communities and employers must be recognized. The support of family members is important to the success of efforts to enhance the work capacity of DI and SSI beneficiaries and should be promoted."

In my view, beneficiaries will be served better by building in more program flexibility, not constructing a more elaborate labyrinth of rules and regulations. One can only speculate that the current rules governing the nine month trial work period, and "substantial gainful activity" may have trapped more beneficiaries into the program than they have helped to rehabilitate.

I am particularly interested in the Council recommendation that Congress should authorize the Secretary to purchase VR services directly from private sector VR facilities, Federal agencies, and State agencies other than State VR agencies. While there may be extenuating circumstances, the December GAO report would lead a reasonable person to conclude that state vocational rehabilitation agencies have done a miserable job of helping social security beneficiaries return to gainful employment. Clearly that ought to be the primary goal of the trust fund monies expended for VR services. I'd like to give the private sector a chance.

I want to compliment Commissioner Hardy for the multiple related demonstration projects she has initiated. Still, I could wish that her predecessors had implemented sooner the demonstration project authority enacted in the 1980 Amendments. I understand the Advisory Council's frustration at the lack of data on alternative work incentives. For example, the concept of a sliding - scale benefit reduction for the working disabled represents a serious departure from the long-standing philosophy that inability to work is the ultimate test of disability. If that concept is to be modified -- in order to encourage otherwise eligible beneficiaries to attempt to work -- we must first have some evidence that a more liberal approach would be cost effective.

Still, we in the Congress must recognize that we created the underlying tension by establishing "substantial gainful activity" as the ultimate test of disability, and then authorizing VR monies to rehabilitate those so disabled they couldn't work. Clearly, many beneficiaries, as GAO reports, have little interest in jeopardizing benefits by cooperating enthusiastically with state VR services.

I want to thank today's witnesses for their testimony. I know they share my interest in improving the disability program, even if our approaches may differ.

Mr. **Daub**. I would like to note the Disability Advisory Council did a thorough job of presenting information for our consideration.

Chairman **Jacobs**. Mr. Gibbons.

Mr. **Gibbons**. I want to thank the witness for a very thoughtful statement. I agree with your reasoning. I appreciate the fine work you have done. Very good.

Chairman **Jacobs**. Mr. Bartlett, you have made an unusually beneficial contribution to the record. The subcommittee thanks you for that.

I have only one question.

You mentioned under your scheme the private carrier would be the payor of first resort, correct? Are there going to be any private carriers? Would there be a disincentive for employers to provide health insurance under those circumstances?

Would you argue if that company is providing them generally for employees, an exception could not be made?

Mr. **Bartlett**. An exception could not be made to in essence under this legislation say that the—a company would only provide health insurance for nondisabled employees. I would have to look in the bill. That may well be current law today.

Let me look that up and provide an answer for the record.

[The following was subsequently received:]

STEVE BARTLETT
3d DISTRICT, TEXAS

COMMITTEES
BANKING, FINANCE
AND URBAN AFFAIRS

EDUCATION AND LABOR

Congress of the United States
House of Representatives
Washington, DC 20515

1709 LONGWORTH HOUSE
OFFICE BUILDING
WASHINGTON, DC 20515
[illegible]

6600 L.B.J. FREEWAY
SUITE 4190
DALLAS, TX 75240
(214) 767-4848

June 6, 1988

RECEIVED
JUN 8 1988
Ways and Means
Subcommittee on Social Security

The Honorable Andrew Jacobs, Jr.
Chairman
Subcommittee on Social Security
House Ways and Means Committee
B-316 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. ~~Chairman~~: Andy

I am writing to respond to your question at the May 26 Subcommittee hearing on whether there would be a disincentive to employers to provide health insurance to disabled employees if they are the payor of first resort and Medicare is the payor of second resort.

Under the Budget Reconciliation Act, P.L. 99-509, Section 9319 requires employers with 100 or more employees who provide employer-based health insurance to provide that health insurance to disabled employees. Under P.L. 99-509, Medicare would be the secondary payer for disabled employees who elect to be covered by their employer's health insurance. This provision expires on October 1, 1991. H.R. 4680, the Social Security Work Incentives Act, does not change this law.

I hope this information is helpful to the Subcommittee

Sincerely,

STEVE BARTLETT
Member of Congress

SB:sql

Mr. BARTLETT. This would not provide a disincentive for employers to hire SSDI recipients. It gives them, in fact, some kind of incentive. Medicare becomes a payor of at least second resort or last resort.

The employee has the incentive to go to work. The employer at least does not have a disincentive to hire the person. It goes into the group policy along with everybody else.

Chairman JACOBS. OK. Thank you very much for your contribution to the record.

Our next witness represents the Social Security Administration itself, David Rust, Assistant Commissioner for the Office of Disability.

Mr. Rust, we will not apply the 5-minute rule to your testimony.

STATEMENT OF DAVID A. RUST, ASSOCIATE COMMISSIONER FOR THE OFFICE OF DISABILITY, SOCIAL SECURITY ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY MALCOLM H. MORRISON, DIRECTOR, DIVISION OF DISABILITY PROGRAM INFORMATION AND STUDIES, OFFICE OF DISABILITY; AND JOHN RITTER, EXECUTIVE PROGRAM POLICY OFFICER, OFFICE OF DISABILITY

Mr. RUST. I have a long statement which I am submitting for the record. With your permission, I will summarize it.

I am accompanied by Dr. Malcolm Morrison, the Director of our Division of Disability Program Information and Studies, Office of Disability. They do the research and gather the data on the disability program.

On my right is John Ritter, the Senior Program Policy Officer in the immediate office of the Associate Commissioner. Both these gentlemen have been with the program for many, many years.

You heard this morning from Dr. Affeldt. Dr. Affeldt and the Council members engaged in spirited debate on disability issues over many months.

I think all of us who sat through those meetings were amazed by the commitment the Council members made and the patience the Chairman displayed in bringing them to a consensus on a wide range of issues.

This morning, Dr. Affeldt briefly went through most of the major recommendations. I would like to talk about some of those areas from the standpoint of our Social Security programs.

The Department of Health and Human Services and other Federal agencies whose programs are covered by the Council's report are currently analyzing all of the recommendations. Therefore, at this time I cannot provide an administration response to every recommendation. I can, however, discuss areas of agreement with the Council's findings and give you the details of specific actions we are taking in response to the report.

In the area of VR effectiveness, the Council believes the current VR programs have not been effective in returning DI and SSI beneficiaries to work. The General Accounting Office report of December 1987 reached the same conclusion.

Fewer than 15 percent of DI and SSI beneficiaries are referred by the State disability determination services (DDS) to the State

VR agencies for services. Fewer than one-half of 1 percent of our DI beneficiaries have their benefits suspended or terminated because they returned to work.

The lack of effectiveness may be due in large part to the characteristics of our beneficiaries. The GAO report notes that approximately 85 to 90 percent of the DI beneficiaries are not realistic candidates for VR either because of their age or because of the nature or severity of their disability.

If we do our job right, Mr. Chairman, we are awarding benefits to people who are so impaired that they are unable to work in the national economy in any job they are reasonably qualified to do.

Assuming the disability determination process moves ahead correctly, we should, therefore, be placing people on the rolls who are too impaired for the most part to work.

The Council's major findings and recommendations are that SSA should focus more attention on providing VR services to these individuals by: one, purchasing VR services from other providers in addition to the State VR agencies; two, collecting better data on the effectiveness of VR; three, exercising more management control over VR programs for our beneficiaries; and, four, ensuring that beneficiaries referred to VR agencies are given highest priority.

GAO's main finding was that the number of beneficiaries who return to work possibly could be increased by making changes in the benefit payment structure. Fear of losing disability cash benefits and Medicare coverage were reasons many beneficiaries gave to explain their reluctance to participate in a VR program.

GAO recommended that SSA carry out a demonstration project to test whether reducing benefits on account of earnings, the benefit offset, would increase the number of beneficiaries who return to work. The Council carefully considered such a policy change, but did not recommend it because beneficiaries would be able to draw reduced cash benefits and Medicare despite earning comparatively large incomes. Also, the proposal would induce more people to come on to the rolls, increasing the Social Security trust fund costs by about $2.5 billion over the first 5 years.

We appreciate the Council and GAO's concern with how effective VR services are delivered to DI and SSI disability beneficiaries. We agree more can and should be done in this area. Our fiscal year 1987 and 1988 research and demonstration efforts are targeted to find new techniques to assist our beneficiaries to return to work. We are seeking additional projects based on recommendations of the Council and, of course, GAO findings, in a research demonstration program (RDP) which was printed in the Federal Register on May 4.

SSA intends to use the knowledge gained from these research and demonstration projects to develop a national VR employment program that will strengthen the cooperative relationship between Federal, State, and private agencies interested in returning our beneficiaries to the work place.

We are not, however, relying on our demonstration activities alone to meet this need. We recognize, as the Council did, that success is largely dependent upon a close, well-coordinated interagency effort on a national scale. We have begun discussions with the Rehabilitation Services Administration in a number of critical areas such as VR referrals, data exchange and the exploration of alternative ways we can work more closely with the rehabilitation agencies in returning our beneficiaries and recipients to the labor force.

The Council was unable to draw definitive conclusions on the effectiveness of DI and SSI work incentives. Many of the incentives are relatively new and sufficient data does not yet exist to measure their effectiveness.

As was noted, Mr. Chairman, the permanent section 1619 in the SSI program was enacted about 18 months ago and went into effect on July 1 of last year. We are just in the first year of operating it as a permanent, ongoing program. We don't have very much data on how it is functioning. We have raw numbers but the overall outcome is still to be determined.

However, the Council was of the opinion that it is reasonable to assume that financial incentives alone are not likely to bring about significant behavioral changes in our beneficiaries. Recommendations made by the Council to SSA in the work incentives area include: first, adjusting the monthly amount of earnings that constitutes substantial gainful activity—it is now $300, they suggested it be raised to $490 and indexed; second, making the SGA level for the blind—now $700 a month—the same as the level for nonblind beneficiaries; and third, increasing the monthly earnings amount that counts towards work periods from $75 to the recommended SGA level which in the first year would be $490 a month.

The Council's recommendations regarding the SGA and trial work period issues would liberalize the work incentive provisions in current law. It would be a significant liberalization.

We agree a reassessment of the substantial gainful activity and trial work period activity is an appropriate and we are currently doing this. I am confident while our approach may not be in total agreement with the Council's proposals, it will be viewed as being responsive to the intent of the Council. We hope to have that out later this year, Mr. Chairman.

The final part of the Council's report concerns issues relating to the determination of disability. These issues are whether the DDS medical specialists should be required in claims involving nonmental impairments and, secondly, the proper use of work evaluations in the disability determination process.

The Council concluded that medical specialist review was not routinely needed in disability claims that involve only physical impairments. The Council encouraged SSA to continue the present policy of using specialists only in those cases where it is warranted.

With regard to work evaluations, the Council found that the use of such evaluations may provide additional information that is useful in the disability determination process but the Council did not believe their use should be mandated.

In conclusion, the Council provided us with a comprehensive examination of the DI and SSI disability programs, with particular emphasis on program benefits that would encourage beneficiaries to return to work. The Council has identified many avenues to explore. We look forward to working with you in the coming months as we consider, both of us together, the Council's recommendations and proposed legislative changes.

That concludes my testimony, Mr. Chairman. I would be happy to answer any questions to the best of my ability.

[The statement of Mr. Rust follows:]

STATEMENT OF DAVID A. RUST, ASSOCIATE COMMISSIONER FOR DISABILITY, SOCIAL SECURITY ADMINISTRATION

I am pleased to be here today to discuss the report and recommendations of the Disability Advisory Council.

Before I discuss the Council's report, I would like to acknowledge the longstanding interest of this committee in the issues addressed by the Council--improving the disability insurance (DI) program and encouraging disabled beneficiaries to work through both effective vocational rehabilitation (VR) programs and work incentives. The mandate for the Council's study of disability issues originated in this committee.

Introduction

The Council was required by law to study the medical and vocational aspects of disability under the DI and supplemental security income (SSI) programs including:

- the effectiveness of VR programs for DI and SSI beneficiaries;
- whether disability determination services' (DDS) medical specialist reviews should be routinely required in claims involving nonmental impairments; and
- the proper use of work evaluations in the disability determination process.

The Council's report includes recommendations in these areas as well as recommendations on work incentives and disincentives and issues related to the determination of disability.

Dr. Affeldt and members of the Advisory Council are to be commended for their dedicated efforts in producing the Council's report. As Secretary Bowen stated, "Throughout its deliberations and in its final report, the Council expressed its commitment to encouraging people with disabilities to attain their fullest potential."

I will address the major portion of my remarks to the Council's recommendations relating to the employment of disabled beneficiaries. The Department of Health and Human Services and other Federal agencies whose programs are covered by the Council's report are currently analyzing the Council's recommendations. Therefore, at this time I cannot provide an Administration response to every recommendation. I can, however, discuss clear areas of agreement with the Council's findings and give you details of specific actions we are already taking in response to the report.

VR Effectiveness

The Council believes that the current VR programs have not been effective in returning DI and SSI beneficiaries to work. The General Accounting Office (GAO) report of December 1987, "Little Success Achieved in Rehabilitating Disabled Beneficiaries," which this hearing today also concerns, agreed with the Council.

Before I discuss the Council's and GAO's recommendations in this area, let me briefly describe how VR services are provided for disabled beneficiaries.

Neither SSA nor the State DDSs that make disability determinations for SSA provide VR services for Social Security claimants. Instead, they refer DI and SSI applicants to State VR agencies for services under the basic Federal/State VR program. SSA reimburses the State VR agencies, on a case-by-case basis, for the cost of rehabilitating DI and SSI beneficiaries when we find that the VR services contributed to the beneficiary's performance of substantial gainful activity (SGA) for 9 continuous months. In FY 1987, SSA approved 4,533 reimbursement claims, at an average cost of about $6,120 per claim and a total cost of about $27.7 million.

The basic Federal/State VR program is administered by the Rehabilitation Services Administration (RSA) in the Department of Education. Eighty percent of the funds for this program come from Federal appropriations and 20 percent from State appropriations. In FY 1986, more than 900,000 people were served by this program and the Federal Government's share of the program's budget amounted to $1.2 billion.

As the Council and GAO reported, the current VR programs are not effective in returning many beneficiaries to work. Fewer than 15 percent of DI and SSI beneficiaries are referred by State DDSs to State VR agencies for services and fewer than one-half of one percent of DI beneficiaries have their benefits suspended or terminated because of work at the SGA level.

This lack of effectiveness may be due, in large part, to the characteristics of our beneficiaries. The GAO report notes that approximately 85-90 percent of the DI beneficiaries are not realistic candidates for VR, either because of their age or because of the nature or severity of their disability. The median age of DI beneficiaries is 55 years and that of SSI disability recipients (many of whom have little or no work experience) is 48 years. Also, because of the strict statutory definition of disability, only the most severely disabled individuals are found entitled to disability benefits.

While many DI and SSI beneficiaries may have little potential for rehabilitation, more can and should be done for those who do.

The Council's major findings and recommendations to improve the effectiveness of SSA's VR programs can be grouped into four areas:

1. VR services--SSA should:
    - foster competition among service providers by purchasing VR services directly from private sector facilities and Federal and State agencies other than State VR agencies,
    - involve employers and unions in the formulation of job training programs for SSA beneficiaries, and
    - provide reimbursement for VR services in certain situations where none is available under present law;
2. Better data--SSA should:
    - collect and analyze data on the effectiveness of SSA's criteria for referral of beneficiaries for VR services and on the characteristics of beneficiaries who are/are not rehabilitated in order to improve the cost-effectiveness of the VR programs;
3. Management control--SSA should:
    - exercise more management control over VR programs for DI and SSI beneficiaries, and SSA and RSA should use compatible data systems to track SSA beneficiaries and facilitate the exchange of information; and

4. VR referral--SSA should:

   - o ensure that DI and SSI beneficiaries referred to State VR agencies are provided services to achieve and maintain gainful employment and are given the highest service priority by the agencies.

The Council believed it was hindered in its deliberations by the lack of data with which to assess alternatives to existing provisions. Therefore, the Council suggested that SSA conduct demonstration programs to: test the potential for direct involvement of beneficiaries in the selection of their VR providers and the design of their VR programs; study the factors which contribute to the successful employment of former beneficiaries who work despite severe impairments; and test the cost-effectiveness of using State VR counselors who specialize in Social Security laws and policies to get beneficiaries VR services and place them in gainful employment.

The Council's findings were not inconsistent with findings in the GAO report. GAO's main finding, based on interviews with VR professionals, was that the number of beneficiaries who return to work possibly could be increased by making changes in the benefit payment structure, since fear of losing disability cash benefits and Medicare coverage are reasons many beneficiaries are reluctant to participate in the VR program.

GAO recommended that the Congress consider directing SSA to carry out a demonstration project to test whether reducing benefits on account of earnings on a sliding disability benefit scale would increase the number of beneficiaries who return to work.

The Council carefully considered such a policy change but did not recommend it because beneficiaries would be able to draw reduced DI benefits and Medicare benefits despite earning comparatively large incomes. Also, the proposal would induce more people to come onto the rolls, increasing Social Security trust fund costs by about $2.5 billion over the first 5 years.

Overall, we appreciate the Council's and GAO's concerns with how effectively VR services are delivered to our DI and SSI disability beneficiaries. We agree more can and should be done. As the Council recognized, however, making VR services more effective involves a complex and often conflicting interrelationship of disability and VR goals and objectives that present challenges for which there are no easy solutions.

Our current research and demonstration efforts are targeted to find out what will work. As you know, Public Law 99-272, the budget reconciliation legislation enacted in April 1986, extended authority originally provided under the 1980 disability amendments (Public Law 96-265, section 505) to conduct demonstrations to test ways of promoting VR and work incentives involving waiver of provisions in Social Security law.

The Research Demonstration Program (RDP), conducted under section 505 authority, is SSA's major demonstration effort on behalf of disabled DI beneficiaries and SSI recipients. The RDP is a coordinated nationwide program of demonstration projects that test innovative approaches for assisting disabled persons to enter or return to the workforce.

SSA intends to use the knowledge gained through the RDP to develop a national VR/employment program that will strengthen the cooperative relationship between the Federal, State, and private sectors in managing the DI and SSI programs. We expect the result to be more disability applicants being referred to, and offered, VR and other employment services and greater numbers returning to work. This would result in savings to the DI trust funds and to general revenues.

Under the FY 1987 RDP, SSA awarded 40 grants to organizations with projects in 27 States and the District of Columbia. Those projects are now underway.

On May 4, 1988, we published the FY 1988 RDP announcement in the Federal Register. This RDP specifically seeks demonstrations based on recommendations of the Council, as well as other sources. We have chosen to pursue as many alternative approaches as possible in our efforts to find the most effective ways to provide gainful employment for disabled beneficiaries.

We are not, however, relying on our demonstration activity alone to meet this need. We recognize, as did the Council, that success is largely dependent upon a close, well-coordinated interagency effort on a national scale.

We have begun discussions with RSA, and we expect to work very closely with them in a number of critical areas such as VR referrals, data exchange, and the exploration of alternative ways we can work more closely with rehabilitation agencies in returning more of our beneficiaries and recipients to the labor market. We have also initiated a dialogue with the Departments of Labor, Treasury, and Justice and are encouraged by their interest in working with us in our efforts to meet this goal.

Issues Related to Work Incentives and Disincentives

The Council was unable to draw definitive conclusions on the effectiveness of DI and SSI work incentives, because many of the incentives are relatively new and sufficient data does not exist to measure their effectiveness. Therefore, the Council noted that the demonstration projects originally authorized by the 1980 amendments are essential to measure the effectiveness of various work incentives. However, the Council was of the opinion, based on the very limited use by beneficiaries of SSA's work incentives, that it is reasonable to assume that financial incentives alone are not likely to bring about significant behavioral changes for DI and SSI beneficiaries.

The Council found that other important factors include family and community support, education, rehabilitation, job placement, and employer and community attitudes, along with periodic review of continued eligibility. They concluded that an effective policy to promote work requires a comprehensive and coordinated approach involving government agencies and, most importantly, the knowledge and resources of the private sector.

Recommendations made by the Council in the work incentive area include:

- adjusting the monthly amount of earnings that constitutes SGA--now $300--to $490 in order to reflect average wage growth since the SGA level was last increased, and indexing the $490 to average wage growth in future years;
- making the SGA level for the blind (now $700 a month) the same as the SGA level for all nonblind beneficiaries (this would be done by holding the $700 level constant for current blind beneficiaries and applying the regular SGA level to individuals newly applying for benefits);

- increasing the monthly earnings amount that counts toward the trial work period (TWP) from $75 to the SGA level;
- moving expeditiously on section 505 work incentive projects and ensuring the projects are of sufficient size and variety to yield fruitful results;
- strengthening existing work incentives by conducting an informational campaign to educate Social Security employees, other Federal and State agencies, community groups, and the public about existing work incentives; and
- conducting a demonstration project to test incentives for individuals' participation in VR programs.

The Council's recommendations regarding the SGA and TWP issues would liberalize the work incentive provisions significantly. We agree that a reassessment of the SGA and TWP criteria is appropriate and are currently doing this. I am confident that while our approach may not be in total agreement with the Council's proposal it will be viewed as being responsive to the intent of the Council.

We agree with the Council that more data are needed to evaluate various work incentives and that to increase return to work significantly, a comprehensive and coordinated approach is needed, including effective work incentives which are clearly communicated, timely referral to VR service providers, and efficient and effective job training and placement methods.

We are also looking closely at the overall concept of assessing SGA and what alternative approaches may exist. Our FY 1988 RDP announcement includes priority areas where demonstration activity can focus on areas related to SGA and TWP. Over the next 2 years we are hopeful that our demonstration activity will lead us to more responsive ways to deal with the issue of assessing the level of work activity.

SSA already has underway employee training and outreach efforts and a public information campaign about opportunities for beneficiaries to return to work. We anticipate conducting additional work incentive projects under the FY 1988 RDP.

Matters of Overarching Concern

I would now like to turn to that part of the Council's report that discussed some possibilities for a fundamental restructuring of the DI and SSI programs over the long term.

The Council found that some fundamental features in the structure of the DI and SSI programs send beneficiaries mixed signals about whether they are expected to try to return to work. For example, beneficiaries must prove that they are so disabled that they cannot do any work for at least 12 months. They are told that under the medical improvement standard for review of their continuing eligibility they will generally stay on the rolls unless they medically improve or return to work. On the other hand, they are referred to State VR agencies for VR services. Because the Council believed data were not available from which to formulate sound restructuring proposals, the Council recommended that SSA undertake demonstration projects. The Council also recommended that SSA sponsor research projects to examine various alternatives to the current DI and SSI programs.

We strongly agree with the Council that the DI and SSI programs should encourage work by beneficiaries whenever possible. Elements of the demonstration projects recommended by the Council are already being conducted under the FY 1987 RDP or will be included in the FY 1988 RDP.

Issues Related to the Determination of Disability

The final part of the Council's report concerns issues related to the determination of disability. Two of the issues considered were specifically mandated in the legislation requiring the Council to be established. These issues were: (1) whether DDS medical specialist reviews should be routinely required in claims involving nonmental impairments, and (2) the proper use of work evaluations in the disability determination process.

In cases where there is evidence of a mental impairment, the 1984 disability amendments require SSA to make reasonable efforts to ensure that a psychologist or psychiatrist completes the medical portion of each case reviewed, including any assessment of an applicant's residual functional capacity, before determining that the applicant is not disabled. Congress did not require such specialty reviews in cases involving physical impairments alone. Instead, it subsequently directed the Council to study the question of using specialists to complete disability determinations at the DDS decisionmaking level, including the question of requiring such specialists to complete the medical portion and any assessment of residual functional capacity in each case.

The Council concluded that medical specialist review was not routinely needed for review of disability claims that involve only physical impairments. The Council encouraged SSA to continue the present policy of using specialist review when, in the judgment of the DDS disability examiner/physician team, such review is warranted. The Council recommended that SSA provide DDSs with guidelines and training in the appropriate use of medical specialists and monitor use of specialists by DDSs to ensure they are used when appropriate. SSA is doing this. The Council also made recommendations on making arrangements with medical schools for specialist review where none is available in the DDS, and on direct SSA funding to encourage the improved capability of physician specialists in evaluating disability. SSA is evaluating these recommendations.

The Council found that the use of work evaluations may provide additional information that is useful in the disability determination process, but the Council did not believe their use should be mandated. Rather, the Council recommended that DDS personnel be properly trained regarding SSA's policy on work evaluations and that SSA exchange the results of work evaluations with State VR agencies to avoid duplication. SSA agrees with these recommendations and is implementing them.

Although not mandated to do so by law, the Council also studied the lack of uniformity in the disability determination process and expressed three concerns:

1. the wide variation in State-by-State allowance rates;
2. the high rate of appeal and reversal of eligibility decisions; and

3. the length of time involved in appealing eligibility decisions.

The Council attributed the lack of uniformity in determinations to a lack of specificity in the rules for determining disability, an inadequately controlled Federal-State arrangement for administering the disability programs, and an appeals process which fails to encourage the development of complete and correct evidence early in the process. Therefore, the Council made various recommendations intended to make the disability criteria more precise, ensure that State disability determinations are accurate, and improve the appeals process.

As the Council's report indicates, the problems relating to the lack of uniformity in disability determinations are longstanding. In recent years, Congress and the Executive Branch have made administrative and program improvements to address these problems. More needs to be done. Although we are not yet ready to address the specific Council recommendations in this area at this time, we would like to make a few comments and call your attention to pending legislation that would partially address the Council's concerns.

The Council, in expressing concern about the uniformity of the disability process from State to State, focused on allowance rate variances. In doing so they recognized that the variances did not necessarily result from program differences from State to State and that demographic and economic factors were a significant influence. The Council was not, however, satisfied that the data available to them were sufficient to draw any accurate conclusions. They did, therefore, suggest that a comprehensive study of these variances be undertaken and specific reasons for them determined.

We have already begun such a study and expect to have the results by the end of this fiscal year. Our study will address all potential factors including those that might affect the application of program policy by the States as well as the full range of demographic and economic influences. Our prior studies have indicated these latter factors represent the principal cause; we will take corrective action if program inconsistencies are identified.

The 1980 disability amendments required SSA to conduct preeffectuation reviews of 65 percent of DI allowances to assure greater uniformity and consistency of State agency decisions. The Council noted that SSA consistently finds the vast majority of allowances it reviews to be correct and recommended that the number of preeffectuation review (PER) cases be reduced. We would like to urge your favorable consideration of the Administration proposal contained in H.R. 2660, the "Social Security Amendments of 1987," that would reduce the number of PER cases and, at the same time, ensure a more effective review of State DDS disability determinations.

Finally, the Council recommended that SSA exercise its full authority under the law to assure that the States are faithfully administering the disability program on behalf of the Federal Government and suggested that financial sanctions or other means to ensure compliance on the part of the States should be authorized. In this regard, I would urge your favorable consideration of another provision in H.R. 2660 which would provide a permanent extension of the State compliance provision in the 1984 disability amendments. This provision, which expired on December 31, 1987, has timeframes and deadlines that permit the Secretary of Health and Human Services to respond swiftly and definitively to a State's failure to make disability determinations consistent with Federal law and guidelines.

Conclusion

The Council has provided us with a comprehensive examination of the DI and SSI disability programs, with particular emphasis on ways to improve the programs so that more beneficiaries will be encouraged to return to work. This Administration is committed to providing people who have disabilities an equal opportunity to compete and achieve. We recognize that many beneficiaries would prefer to be self-sufficient. The Council has identified many avenues of exploration and we look forward to working with the Congress in the coming months as we both implement Council recommendations and propose legislative changes, as appropriate.

That concludes my testimony. I will be happy to answer any questions you may have.

Chairman **Jacobs**. Mr. Daub.

Mr. **Daub**. No questions.

Mr. Chairman, I appreciate the summary and the detailed testimony you have given to us.

Chairman **Jacobs**. Mr. Rust, I just thought of an unfair questions. What do you think of Mr. Bartlett's proposal?

Mr. **Rust**. Do you want a snap judgment? We have not had a chance for any analysis and I think it would be inappropriate to even venture a guess as to what our findings will be when we cost out the proposal.

However, we costed out a similar benefit offset proposal submitted to the Disability Advisory Council last summer. That proposal was developed during a conference last summer held by the Department of Education. While this proposal may differ significantly from what the Congressman put forth, our actuaries told us the proposal would probably increase the rolls about 5 percent. Our actuaries say that for every person on our rolls there are a number of people, and the numbers vary, but people equally impaired, who are in the work place and not on the rolls.

The Office of the Actuary believes that over time a certain number of those people would in fact come on the rolls and then return to work. They believe it would be about a 5-percent increase in the rolls and a $2.5 billion impact on the trust funds during the first 5 years.

The other factor I thought was interesting in that proposal was—as you worked the offset, you could have people earning as much as $18,000 or $19,000 a year before their cash benefits would go down to zero. There were some categories of people receiving especially high benefits who might be able to earn close to $30,000.

The offset could allow people to work at substantial levels and draw some benefits and continue to keep their Medicare coverage. I think these are issues we need to wrestle with.

We will be glad to look at Congressman Bartlett's bill and give you a reaction.

Chairman **Jacobs**. I infer that off the top of your head you prefer a pilot test of it, if it were going to happen at all.

Mr. **Rust**. I think I could safely say yes to that.

Chairman **Jacobs**. You haven't been in touch with anybody.

Mr. **Rust**. I will go out on a limb on that one, Mr. Chairman.

Mr. **Daub**. There is nobody in town to be in touch with.

Chairman **Jacobs**. There are 900 going on the trip?

Mr. **Daub**. They were all there.

Chairman **Jacobs**. Can't let the Russians outnumber us.

Mr. **Rust**. I was invited, Mr. Chairman, but I told them I had to testify this morning.

Chairman **Jacobs**. What about the SGA? Does the administration have any plans to adjust it now? If so, what are they?

Mr. **Rust**. The answer is yes. We are wrestling with a plan at this time. We have several options on how to do that. I have two concerns. These are personal concerns.

One is that if we raise the SGA level too high, and you begin to get to the point where it equals or exceeds the minimum wage, working full time, I guess the question in my mind is do we want to say that working at that level is not substantial gainful activity on a full time basis?

A second concern is it is my belief that we should look at the SGA level not as some sort of measurement of income to live on, but as a measurement of a person's ability to work, because of the basic premise of this program. As Dr. Affeldt pointed out, Congress may well want to look at the basic premise of the problem. I certainly have no objection to doing that. The basic premise of the current program is that people on the disability rolls are so severely impaired they are unable to work. The GAO finding is in most cases that is the case.

You have a question of at what level should benefits be terminated. You have one standard to come on the program, which is you are found to be unable to work in the national economy. Then do you have another standard which says you can work at levels that are very substantial.

I think you have a question then of one standard to come on the rolls and another to stay on the rolls.

I just think these are things we need to wrestle with and decide what our national policy should be.

Chairman Jacobs. Would the record accurately reflect the truth if we said that the Administration is inclined to adjust the SGA but it has not arrived at a figure?

Mr. Rust. Yes, I think it is our intention right now to raise it—we would hope to have it in place by the end of the year. We are still debating the proper level.

We will see how much it would cost.

We are likewise looking at the trial work measurement, too. There is an intention to raise that.

Chairman Jacobs. Do you want to comment on the disparity between the blind and other disabilities?

Mr. Rust. Maybe I should have gone on the trip.

Chairman Jacobs. Depends on how diplomatic you are.

Mr. Rust. Let me take a stab at that. I always wanted to be an ambassador.

As a rule of thumb, I would say we should not have differences in the program based on specific conditions. I think a standard should apply across-the-board. We get requests for the elimination of the 5-month waiting period for people who are terminally ill, with AIDS, with cancer. Over the years SSA has tried for the most part, to maintain as few exceptions as possible.

We are looking now at what the implications are of the two different levels of SGA. I think at this point we are very unlikely to propose to Congress legislative changes in the way the blind SGA level is calculated. That is still not 100 percent decided. I am pretty confident we will not be making such a legislative proposal.

Chairman Jacobs. Thank you. We thank the administration for their time and thoughts.

Mr. Rust. Thank you, Mr. Chairman.

Chairman Jacobs. We are now favored by testimony from the General Accounting Office, Mr. Frank Frazier, Associate Director.

STATEMENT OF FRANKLIN FRAZIER, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY KEN LIBBEY, EVALUATOR IN CHARGE, AND CAMEO ZOLA, ASSIGNMENT MANAGER

Mr. **Frazier.** Good morning, Mr. Chairman.

I have with me Ken Libbey, Evaluator in Charge, and Cameo Zola, Assignment Manager.

At the request of your subcommittee, we studied the relationship between the vocational rehabilitation programs and the Social Security disability insurance program. We found that vocational rehabilitation has had very little effect on removing beneficiaries from the Social Security rolls.

For example, we studied persons who became disability insurance beneficiaries in 1983 and found that 3 years later in 1986 only 1 percent had left the benefit rolls because of working, and less than one-third of those who left the rolls had received services from a State vocational rehabilitation agency.

We also found that of the beneficiaries who had some vocational rehabilitation experience, nearly two-thirds began with the vocational rehabilitation agency before they were granted disability insurance benefits.

Last, we found that many beneficiaries who completed vocational rehabilitation programs had earnings either less than their disability insurance benefits or not enough to make it worth giving up their benefits.

We also studied referral policies of States and found that some States are more active than others in referring disability insurance claimants to vocational rehabilitation agencies and getting them involved in vocational rehabilitation programs. However, the variances in the referrals have had little effect in getting people off the disability insurance rolls. For example, a State with a high referral rate has not been any more successful in removing beneficiaries from the roll than a State with a low referral rate.

Vocational rehabilitation counselors attribute some of the low participation rate of beneficiaries in the rehabilitation programs to three factors. One, most disability insurance beneficiaries are reluctant to get involved with vocational rehabilitation because many feel they are too disabled to work and many are afraid of losing their disability insurance and Medicare benefits.

Second, beneficiaries are generally older and more severely disabled and, therefore, they have a low probability of success.

Third, those beneficiaries who try rehabilitation are generally younger persons and self-motivated. Most vocational rehabilitation counselors believe more beneficiaries would attempt to work if their disability insurance benefits were reduced on a sliding scale as their earnings increased, and even more would attempt to work if they were also offered indefinite continuation of Medicare benefits.

The GAO originally suggested a sliding scale benefit concept in a 1976 report. In the 1980 disability insurance amendments, the Congress directed the Social Security Administration to experiment with such an approach in a demonstration project. To date, the Social Security Administration has not conducted such an experiment. We believe that the Social Security Administration should undertake a demonstration project to determine whether a sliding scale approach would encourage more beneficiaries to return to work.

This concludes my abbreviated statement. We will be glad to respond to any questions you may have.

[The statement of Mr. Frazier follows:]

STATEMENT OF FRANKLIN FRAZIER, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

We are pleased to be here to discuss the results of our study of vocational rehabilitation services provided to beneficiaries of the Social Security Disability Insurance (DI) program. In response to a request from your Subcommittee, we reviewed the rehabilitation program and reported to you on February 3, and December 7, 1987.[1]

Since the beginning of the DI Program, the Congress has encouraged the Social Security Administration (SSA) to refer claimants to state vocational rehabilitation (VR) agencies. From 1965 to 1981, SSA was authorized to provide substantial funding to VR agencies to pay for services provided to DI beneficiaries. Over the years, however, few beneficiaries returned to work and left the DI rolls. Since 1981, SSA has reimbursed VR agencies only for demonstrated successes, defined as placing a DI beneficiary in substantial gainful activity for 9 months or more. Under this policy, SSA funding of VR agencies fell sharply and VR agency services to DI beneficiaries also declined.

Age and disability conditions keep many DI beneficiaries from returning to work, and others are dissuaded by economic disincentives. A large majority of DI beneficiaries, approximately 85-90 percent based on our data, are either too old to be considered realistic candidates for vocational rehabilitation or are unlikely candidates because of the nature of their disability. Also, individuals who have just gone through the experience of convincing SSA of their total disability may not be very receptive to offers of rehabilitation.

STUDY OF 1983 CLAIMANTS

We studied DI claimants granted benefits in 10 states in 1983. By February 1986, only 1 percent had left the DI benefit rolls due to working. This 1 percent includes people who returned to work without benefit of VR services. Less than one-third of those who left the rolls had received services from a state VR agency.

The beneficiaries who had been evaluated for services by VR agencies generally were much younger than those not evaluated. In our study, those with no VR contact had a median age of 56, while those with VR experience had a median age of 33. Certain types of disability conditions were more prevalent among the beneficiaries evaluated for VR services than among the general DI beneficiary population. For example, those who had been injured in accidents or had visual, hearing, or mental impairments accounted for 63 percent of those evaluated for VR, but comprised only 25 percent of the DI population.

About 12 percent of the DI beneficiaries had some VR experience, and nearly two-thirds of these had received services from a VR agency before they were granted DI benefits. For the most part, claimants who do have some rehabilitation experience were referred to the VR agencies by someone other than the state disability determination service (DDS). Examples of other referral sources are hospitals, doctors, local social agencies, and self-referrals.

In our study, the claimants who successfully completed rehabilitation programs often had low earnings. About

---

[1] Social Security: State Vocational Rehabilitation Agencies' Reimbursement for the Disabled (GAO/HRD-87-36BR, February 3, 1987).
Social Security: Little Success Achieved in Rehabilitating Disabled Beneficiaries (GAO/HRD-88-11, December 7, 1987).

60 percent were earning less than their DI benefits (counting spouse and child benefits, where appropriate). Some who earned more than their benefits apparently did not earn enough more to justify giving the benefits up. The nine percent who did leave the DI rolls had earnings averaging $746 per month more than their DI benefits.

REFERRAL POLICIES OF STATES DIFFER

The 10 states we studied varied considerably in the percentage of DI beneficiaries referred to VR agencies, from 41 percent in Wisconsin to about 2 percent in California. The VR agencies made varying efforts to contact and evaluate the referrals. But these state differences seemed to have little effect. All remained very low in the percentage of DI beneficiaries who left the rolls because of working. Connecticut, one of the less active states in terms of referrals, had the highest success rate with 5 beneficiaries per 1,000 leaving the DI rolls.

VR COUNSELOR VIEWS

VR counselors believe there is low participation by DI beneficiaries in VR programs because most often beneficiaries either believe they are too disabled to work or they are afraid to risk losing their DI and Medicare benefits. Many counselors commented that loss of Medicare was a significant concern to disabled persons because they fear they would not be able to replace it with other health insurance.

The counselors, in general, viewed DI beneficiaries as an older and more severely disabled client group, with a low probability of suceeding in a VR program. Those who do participate in VR programs were often younger persons who were motivated by a desire to return to the workforce.

Counselors believe the currently available work incentives are helpful to beneficiaries who are anxious to return to work, but are not likely to induce others to attempt working. Current incentives include a 9-month trial work period, extended Medicare benefits, and a 15-month extended period of eligibility during which a terminated beneficiary may stop working and return to the benefit rolls without a new application. Counselors generally believed more beneficiaries would attempt working if their Medicare benefits were continued indefinitely and some of their DI benefits were continued on a sliding scale based on earned income. More than 90 percent of the counselors believed these two changes would encourage more beneficiaries to try working. In fact, 65 percent of the counselors said that substantially more would attempt to work.

We believe that no significant increase in work activity by DI beneficiaries is likely without a benefit change that would create an incentive to work. Under the current benefit structure beneficiaries have little incentive to attempt working unless they are capable of earning substantially more than their tax-free DI benefits. If current beneficiaries engage in substantial gainful activity (essentially $300 per month of earned income)[2] for more than 9 months, they lose their DI benefits and, after a grace period, their Medicare benefits. Even under a new approach, the increase in work activity would be limited because most DI beneficiaries are unlikely candidates for vocational rehabilitation.

---

[2] For blind beneficiaries, the amount in 1987 was $690 per month.

DEMONSTRATION OF A SLIDING BENEFIT SCALE

We suggested a sliding benefit scale in a 1976 report.[3] Under such a system, a beneficiary who returned to work would lose a portion of his benefits based on his earned income. This would allow him to increase his income while retaining his beneficiary status. The trust fund would benefit from lower payments to these individuals, in some cases no payments at all.

In 1980, the Congress directed SSA to experiment with a reduced benefit approach. SSA made plans for such an experiment, but to date has not carried them out. The Congress renewed SSA's authority for a demonstration in 1986. In 1987, SSA provided us a list of demonstration projects it was pursuing, but these did not include a demonstration of the sliding scale concept. We believe that it would be worthwhile to pursue a demonstration project to determine whether providing benefits on a sliding scale would reduce DI costs.

This concludes my statement. We will be pleased to answer any questions.

---

[3] Improvements Needed In Rehabilitating Social Security Disability Insurance Beneficiaries (MWD-76-66, May 13, 1976)

Chairman **Jacobs**. Mr. Daub.

Mr. **Daub**. No questions. Thank you.

Chairman **Jacobs**. It seems to me the general tenor of your report tracks pretty well with the testimony we have heard earlier today. As Clint Eastwood says, it is the third time we heard it, so it must be true.

Mr. **Frazier**. Yes, sir. It tracks it. As a matter of fact, we made comment in the back of the room that we have heard our testimony.

Chairman **Jacobs**. Redundancy will probably impress most of us.

Thank you for your consideration.

Our next witness is our friend, Dr. Arthur Flemming, whose pedigree is far too long to read at this time. When Eugene McCarthy ran for President, we said the only reason he did it was that it eliminated long introductions.

We will only say, "Mr. Flemming."

STATEMENT OF ARTHUR S. FLEMMING, COCHAIR, SAVE OUR SECURITY COALITION (FORMER SECRETARY, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE)

Mr. **Flemming**. Mr. Chairman, thank you very much for the opportunity of appearing before you on behalf of SOS. This is a coalition of over 100 organizations dedicated to the maintenance and improvement of the Social Security program.

I submitted to the committee a statement. I would appreciate it being made part of the record.

I would like to make just a few comments based on that statement and based on the testimony that I heard today.

I was very much interested in the GAO report. In the introduction to that report, they dealt with some history. In that historical portion, the GAO said,

> When the Congress established SSDI cash benefits in 1956, it expressed its intention that applicants be referred promptly to State vocational rehabilitation agencies to the end that the maximum number of such individuals may be rehabilitated into productive activity.
>
> In 1960, the Congress authorized a trial work period during which SSDI beneficiaries could still receive benefits, and in 1965, use of SSA trust funds to support State rehabilitation services to beneficiaries.

As you know, in the 1958 to 1961 period, I was serving as the Secretary of Health, Education, and Welfare. It was my practice to hold staff meetings every Tuesday afternoon. The participants were people reporting directly to me and one of those persons was Mary Switzer who was in charge of vocational rehabilitation. Very early in the period that I served as Secretary, she raised the issues that are reflected in those comments from the GAO report.

She got my attention, and I have been very much interested and very much concerned about the issue ever since, and I have been unhappy over the fact that we have not made, it seems to me, the substantial progress that could be made in dealing with the issue.

I feel that this committee and all of us working in the field have been helped in our understanding of the issue by the work of the advisory committee whose report is now before you, as well as by the report of the GAO.

However, the development that gives me great encouragement is the introduction of the bill which has been outlined here this morning, the bill which, as I understand, has been introduced by Representatives Bartlett, Levin, Matsui, and Gradison.

I feel that the enactment of this bill would represent a very significant forward step in opening up opportunities for disabled persons to achieve their highest possibilities.

Personally, it seems to me that the bill is moving in the right direction because it parallels the provisions in the supplemental security income, 1619(a) program.

As this committee knows, we have had success with that program since it was enacted, really rather remarkable success. If the bill that has now been introduced is enacted into law, it will reduce confusion for concurrent beneficiaries as well as those on supplemental security income who will become title II eligible as a result of working.

Second, the "disabled and working status" is designed to assure that the person receives an economic benefit from working while also gradually reducing his or her reliance upon the Social Security disability insurance program.

I think the introduction of that concept of disabled and working is a very constructive step, and I certainly hope that it will find its way into law.

Then, third, the availability of Medicare both during the 48 months currently available as well as through the buy-in component later will assure that a person who takes the risk and attempts to return to work will be able to continue to secure health coverage if he or she is otherwise unable to secure comparable coverage through his or her employer.

As recognized in the bill, and as brought out in the discussion that has taken place here in the hearing, we feel it is critical that the program be designed to assure that neither disability insurance nor Medicare are means tested.

As I see it, the bill, as drafted, as it stands at the present time, is designed to effectively meet these concerns.

I have listened to the suggestion that possibly the way to get started down this road is through a demonstration program. Personally, I would be opposed to that approach. It seems to me we have all the evidence we need to move on this, and I guess I have a bias against demonstration projects. They are great for the people that happen to be involved in the projects, but they constitute the worst kind of discrimination against all the other persons who are unfortunate enough not to be involved in a demonstration project.

It seems to me that on the basis of the experience that we have had with the SSI program, on the basis of the studies that have been made, that as a nation, we are ready to move on this. We are not going to take much of a risk by moving at this particular time, and we are going to open up opportunities for a goodly number of persons.

At the present time, the persons affected have obstacles standing in their way. They are legitimate obstacles. They are legitimate concerns from their point of view. This bill would remove a lot of those obstacles and give them the feeling that they could strike out and could move in the direction of achieving their highest possibilities as citizens of our nation.

So personally, I would hope that the committee could move expeditiously to consider the legislation, that it could be reported out, and that we could get favorable action on the part of both the House and the Senate.

I might even be bold enough to suggest that conceivably we could get favorable action in this session of Congress. This would be a great message to send to the people we are talking about here and who do confront these obstacles and who consequently are not in a position as they see it, and we can't quarrel with them in most instances, to really achieve their highest possibilities.

When we are dealing with people who confront obstacles of this kind, I think that their situation dictates action now not 2 or 3 years down the road after we have evaluated a demonstration project.

Thank you, Mr. Chairman.

[The statement of Mr. Flemming follows:]

Arthur S. Flemmming
Co-Chair of the SOS Coalition
Before The Ways and Means Subcommittee on Social Security
May 26, 1988

Mr. Chairman. I am the co-chairman of the Save Our Security (SOS) Coalition. The Save Our Security Coalition is a coalition of over 100 organizations dedicated to the maintenance and improvement of Social Security programs.

I am pleased to appear before the Subcommittee today to discuss the very significant work incentive problems involved in the implementation of the Social Security disability program.

The work incentive recommendations of the Disability Advisory Council are very disappointing. The Council cited the fact that only 1/2 of 1% of disability insurance beneficiaries leave the rolls to return to work. It also recognized that "the Supplemental Security Income program for people who are disabled or blind contains strong work incentives for beneficiaries through the provision of Section 1619 and the plans for achieving self-support" (page 4). Despite those facts, the Council said there has not been enough experience with the work incentives which currently exist in Social Security Disability Insurance and public education about these incentives is what is needed. This conclusion, however, must be considered in the light of statistics sited earlier namely that despite, the current provisions, many of which have existed for years, only 1/2 of 1% of Social Security Disability Insurance beneficiaries return to work.

While the Council's recommendations to increase the Substantial Gainful Activity (SGA) and the trial work period dollar levels are helpful, they are not enough. In addition, their proposal to whittle away at the higher Substantial Gainful Activity level for blind individuals is unfortunate. Rather than recognizing that the higher level for blind individuals was created by Congress to facilitate return to work and that it is inequitable that other Social Security Disability Insurance beneficiaries have a lower test, the Council concludes that the only inequity is that the blind level is higher and therefore must be lowered. To implement this recommendation will simply create a new work disincentive in this program.

It is ironic that, despite the fact that the Disability Insurance and Supplemental Security Income (SSI) programs have exactly the same standard of disability, it is only SSI, where no connection to the work force is required to establish eligibility, that has a work incentive program well-suited to disabled individuals' needs. While some individuals receiving Disability Insurance benefits as disabled dependents may not have a work force connection, by definition, all other Disability Insurance beneficiaries have worked.

In 1986, in Public Law 99-643, the Congress acted to make permanent and improve the Supplemental Security Income work incentive program, known as " Section 1619 (a) and (b)." The March, 1988 statistical report on 1619 makes it clear that the Supplemental Security Income program is now designed in a manner which facilitates the return to the work force of individuals with disabilities.

According to the Social Security Administration report, "most of the section 1619 (b) participants received a Social Security benefit payment (53.8 percent)." Also, the age range of those Supplemental Security Income recipients who participate in section 1619 program is very heartening: while the largest proportion of both section 1619(a) and (b) participants were in the age 22-29 age group, 10.1% of the 1619(a) participants and 12.3% of the 1619(b) participants were 40-49 years old. In addition, 7.9% in 1619(a) and 10.1% in 1619(b) were between 50 and 64. In other words, this program works for all ages of disabled individuals, including those Social Security Disability Insurance beneficiaries whose Social Security benefits are low enough to permit them to also be eligible for Supplemental Security Income and whose trial work periods have not yet expired.

The challenge of the Supplemental Security Income program is to design a parallel program for the Social Security disability program. It must be designed consistent with the principles of social insurance. And, given the successes in the Supplemental Security Income program and the clearly stated need of disabled individuals for a similar program in Disability Insurance, steps must be taken now to make the necessary adjustments in the Disability Insurance program. This is not the time to study the issue further, to design "pilot" projects and "demonstrations." In effect, the Supplemental Security Income 1619(a) and (b) program has provided precisely the information the Congress needs: with necessary income and health benefit supports, individuals with disabilities who currently remain on the Disability Insurance rolls, out of fear of loss of income and health benefits, will attempt to return to work.

The bill which Representatives Bartlett, Levin, Matsui, and Gradison introduced yesterday is well-designed to assure that Disability Insurance beneficiaries can attempt to return to work. First, it parallels the provisions in the Supplemental Security Income 1619(a) program. This will reduce confusion for concurrent beneficiaries as well as those on Supplemental Security Income who will become Title II eligible as a result of working. Second, the "disabled and working status" is designed to assure that the person receives an economic benefit from working while also gradually reducing his/her reliance upon the Social Security Disability Insurance program. Third, the availability of Medicare, both during the 48 months currently available as well as through the buy-in component later, will assure that a person who takes the risk and attempts to return to work will be able to continue to secure health coverage if he/she is otherwise unable to secure comparable coverage through his/her employer. As recognized in the Bartlett/Levin/Matsui/Gradison bill, it is critical that the program be designed to assure that neither Disability Insurance nor Medicare are means-tested. This bill is designed to effectively meet these concerns.

We urge this Subcommittee to consider this bill as soon as possible. It represents a significant step in reassuring that some disability insurance beneficiaries are able to return to work. This proposal also recognizes what the Council failed to fully consider: there are not only social but also economic benefits to this society when beneficiaries return to work. Not only do they receive reduced (or no) disability insurance benefit, they also are paying income and payroll taxes. Passage of this bill should not be delayed. The successes in the 1619 program clearly emphasize the losses created by delaying similar improvements in the Disability Insurance program.

The GAO's survey of Vocational Rehabilitation officials and counselors points out the advice of experts in this program over the past decades. Namely to design a system which assures not only retention of Medicare but also a sliding benefit scale. In 1980, Congress authorized the Secretary to create demonstration projects dealing with these issues. It is only now, long after final action should have been taken, that SSA has begun to undertake any demonstration projects. Disability beneficiaries have waited long enough. SSA can and is looking at vocational rehabilitation issues in its demonstrations. Elimination of these work disincentives would only help to improve the likelihood of vocational rehabilitation programs working. We support the Social Security Work Incentives Act of 1988, HR 4680. This is a bi-partisan effort to provide a good reasonable approach to the very work disincentive problems that Social Security Disability beneficiaries face. We urge this subcommittee to act immediately on this bill.

Chairman Jacobs. Dr. Flemming, you may well be right, that we have the information. The question that remains is whether we have the votes.

Mr. Flemming. I recognize that.

Of course, those of us who are on the outside and who believe in something of this kind should be helpful in trying to persuade people that the time has come for action.

I think there would be real support for this out at the grassroots. I think people see this problem and people at the grassroots support it and would be willing to articulate their support now that they have a handle to take hold of in the form of this bill that has been introduced.

After all, under SSI, we did not have too much success with the concept when it was just a demonstration project. But once Congress said we are going to cross the line and we are going to put it into effect for everyone, then it began to move and move in a significant way.

Chairman Jacobs. Right. We thank you for your testimony, sir.

Mr. Flemming. You are welcome. I appreciate the opportunity.

Chairman Jacobs. Inspired by your presence.

Our first panel consists of the American Foundation for the Blind, Scott Marshall; National Council on Independent Living, Robert Gorski; and the National Mental Health Association, Michael Wilson.

STATEMENT OF SCOTT MARSHALL, GOVERNMENT RELATIONS SPECIALIST, AMERICAN FOUNDATION FOR THE BLIND

Mr. Marshall. Thank you, Mr. Chairman.

Chairman Jacobs. I believe we will now be constrained to the 5-minute rule.

Mr. Marshall. Mr. Chairman, I am Scott Marshall, representing the American Foundation for the Blind. We have submitted a detailed statement for the record and I will summarize my remarks.

I think we all agree we need to create new work incentives and eliminate the disincentives which are presently part of the program. We have been talking about these disincentives and incentives on the beneficiary side of the equation. We must not lose sight of the fact of the need to create incentives for the rehabilitation system to do a better job in rehabilitating Social Security beneficiaries is also needed.

I will speak more about that later.

First, let me turn to the SGA proposal contained in the Council's report. I was glad to note Dr. Affeldt recognized the inequity between blind and otherwise disabled individuals relative to the SGA amount. Unfortunately, the Council has attempted to fix one inequity by creating another one.

The proposal to reduce the SGA amount for new blind beneficiaries and to freeze the SGA amount at $700 per month without anything for existing beneficiaries is punative and shortsighted. We realize that developments in this law have been an evolutionary process over the years.

Changes have sometimes been made which affect the blind first and then have been carried forward to other disabled people. We believe that at this time, fairness and equity demands that blind and other disabled people share the same SGA amount of $700 per month, that this amount should be indexed, and that there should be a phaseout of benefits, $1 in benefits for each $2 in earnings, similar to the phaseout presently applied to retirees aged 65 to 69.

To do anything less creates a further work disincentive which we do not need to exacerbate.

A second work disincentive is the issue of health insurance. We recommend that Medicare coverage should be available to all SDI beneficiaries from the day of eligibility and that this coverage should continue until there is a medical recovery.

However, if the individual earns above the SGA amount, as modified by our proposal, the individual would then pay for his coverage himself or herself.

Turning to the rehabilitation proposals in the report, we believe that every SSDI beneficiary should expect the opportunity to leave the program. That is what we are all about, or what we should be all about here. This means that every SSDI beneficiary should expect a competent rehabilitation evaluation and, if indicated, an array of services, designed to maximize employment or, at a minimum, to enhance quality of life.

We believe that the proposal to permit the SSA to contract out for services with agencies other than the State VR agencies is a good proposal. However, we believe that the Secretary should develop standards to ensure quality and accountability of service and that, although not recommended in the DAC report, the reimbursement practice which was formerly in existence prior to 1981, which permitted the rehabilitation provider to be paid even if the rehabilitation is not successful should be reestablished.

To do this, gentlemen, is required because quite frankly, if we need or want the rehabilitation system to do a better job in rehabilitating blind and disabled people, we have to put a sweetener in the pot. We feel that improving the reimbursement mechanism will help the rehabilitation system address its responsibilities to SSDI beneficiaries.

We have several other recommendations in our statement. In the interests of time, I would be happy to take any questions as you wish.

[The statement of Mr. Marshall follows:]

STATEMENT OF SCOTT MARSHALL, AMERICAN FOUNDATION FOR THE BLIND

I am Scott Marshall, Government Relations Specialist for the American Foundation for the Blind.

The American Foundation for the Blind, founded in 1921 through the inspiration of Helen Keller, is a national voluntary research and consulting organization in the field of services to blind and visually impaired persons of all ages. The trustees and executive director of the Foundation are greatly interested in, and concerned with, the opportunities for employment of blind persons and otherwise disabled individuals. They wish to see that all individuals with disabilities are provided incentives to enter or remain in the labor force. However, we wish to see that opportunities and work incentives are such that the working individual is able to earn an amount to support himself/herself and a family and to obtain necessary health insurance.

I want to discuss three aspects of the Disability Advisory Council's (DAC) report. They are work incentives, substantial gainful activity, and rehabilitation services.

WORK INCENTIVES AND THE SGA AMOUNT

We believe that creating incentives to work through inducements to seek and obtain financially rewarding employment is the most effective way of reducing the SSDI rolls for those beneficiaries whose disabilities are not so severe as to preclude any substantial gainful activity. With that in mind, we cannot understand the punitive and short sighted recommendation of the DAC to lower the earnings level for determining substantial gainful activity (SGA) for those individuals awarded disability benefits on the basis of blindness in the future, and the freezing of current SGA earning levels for blind persons now on the SSDI rolls. As you know, the current SGA earnings level for blind persons is tied to the retirement earnings level for those aged 65-69 (without the phase-out of $1 of benefits for each $2 in earnings above that). This has been in effect since 1978. This year, the SGA level is $700 per month for blind persons. Action to lower that level would only create a further disincentive and would not create any appreciable program savings.

The Advisory Council ties its recommendation for creating a further work disincentive for blind persons to a possible increase in SGA earning levels for those who are disabled for reasons other than blindness. We think that all disabled individuals who meet the Social Security disability criteria should have the SGA earnings level now in effect for blind persons. The current SGA level of $300.00 per month for the non-blind disabled is not even at the Supplemental Security Income (SSI) federal benefit level of $354.00 per month.

We recommend that the SGA earnings level for all disabled persons be established by law and indexed at the level for aged 65-69 retirees, with a phase-out of $1 of benefits for each $2 in earnings. If Congress does not see fit to permit the earnings phase-out now, we recommend a demonstration program to test this proposal.

Another work disincentive results from the loss of health insurance benefits by individuals who earn more than the SGA amount. Individuals may therefore artificially limit their earnings in order to preserve valuable health insurance benefits. Such a result is certainly not unexpected since one could hardly blame an individual for attempting to preserve benefits for himself and his family. We recommend that Medicare coverage be provided when the individual is awarded SSDI benefit payments, and that such coverage be continued so long as the individual has not medically recovered. For example, a disabled person could earn enough to phaseout SSDI benefits yet not have medically recovered, in which case Medicare should be continued with premiums paid for by the individual. Under the current system, the disabled person must be in receipt of disability payments for 24 months before Medicare coverage is provided plus the five-month waiting period. This is a time when health insurance is needed most to either aid in recovery or help prevent a worsening of health conditions.

Continuation of health benefits is particulary important since most disability beneficiaries could not afford, or obtain, private insurance coverage. According to the January 1988 GAO report (GAO/HRD-88-35BR) concerning demographics of SSDI beneficiaries, claimants were predominantly older, more likely to be male, poorer, with education levels averaging lower than the general population and, most had multiple health problems. Total median net worth, excluding residence, reported by disabled beneficiaries under age 55 was only $54.00; for those between ages 55-64; $1,114.00. We also point to the following as indicative of the low income levels of SSDI blind recipients. We find that of the 83,115 individuals who are blind and in receipt of SSI payments, 38.8% (or 32,248) receive an SSDI benefit so low that they qualify for an SSI payment. (see Social Security Bulletin Annual Statistical Supplement, 1987, tables 204 and 205.) According to table 46 of the bulletin, the average SSDI benefit of a disabled worker was $473.80 per month in 1986.

With an SGA level as recommended, as well as elimination of the trial work period and continuation of health care coverage, there would be incentives for disabled individuals to attempt to return to the labor market. In addition, the program would be greatly simplified for the disabled individual and for the Administration. As you know, the Secretary of the Department of HHS and preceding secretaries are authorized by law to "...by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity...." Unfortunately, no secretary has seen fit to provide additional incentives for the disabled after 1979 when the SGA level was set at $300.00 per month. The Congress did see fit to establish a different level of SGA earnings for blind persons, effective for 1978, and thereafter indexed it to the age 65 retirement earnings test. The same changes could have been made effective for all disabled persons through regulations, as well as other work incentive provisions.

Work incentives can be created by: training; assistance in obtaining employment; engineering to make job performance possible; earnings levels supportive of the workers' needs; and not least, the opportunity to receive disability payments again, if the work experience is not successful.

In discussing the Advisory Council's recommendations concerning those who are disabled by blindness, we have tried to assess the impact by the number that could be affected. As the Advisory Council found, there is limited data; the Social Security Administration could provide us with very little information about the numbers who are on SSDI because of blindness, or about the number of blind persons who are working or who have worked while on the SSDI rolls.

Over the past year, we have obtained informally undocumented information that indicates that approximately 90,000 blind persons receive SSDI benefits. Using this figure and applying other known information, we estimate that many blind beneficiaries are unable to work, principally due to advanced age. First, SSA has provided us with data showing that (in 1984) 4,822 claims by statutorily blind applicants were awarded. Out of that number, 19.9% were over age 60, 27.1% were age 50 - 59 and 16.4% were under age 30. There is not a great likelihood that those blind persons over age 50 will obtain a significant level of employment, due to many factors such as age discrimination. Such individuals may, however, benefit from rehabilitation services designed to assist them to regain employment. Also, many blind persons have other significant disabilities. Using these data, it is difficult to project the number of blind SSDI beneficiaries who would be employable.

The Social Security data show that a larger number of awards were made in the years 1980 through 1983 than the 4,822 awards in 1984. There were 5,926 awards in 1980, 5,490 in 1981, 5,045 in 1982 and 5,474 in 1983. The percentages of those awards to recipients "under age 30" dropped from 23.6% in 1980 to the 16.4 in 1984. The cost savings resulting from lowering and freezing the SGA amount, as measured by benefit dollars paid out, will only be minimal, but could result in a tremendous cost when measured in terms of lost productivity and earnings through the creation of an even greater work disincentive. In view of the great difficulties disabled persons experience in qualifying for disability insurance benefits, Congress should mandate work incentives that are fair to beneficiaries and operate as a cost savings to the system.

Vocational Rehabilitation

In reviewing the DAC's report and recommendations relative to rehabilitation of SSDI recipients, we can only reflect on a summary of the GAO report HRD-88-11 of December 7, 1987 which states: "Despite Congress' desire to have as many beneficiaries of Social Security's disability insurance program rehabilitated to productive employment, relatively few have been placed in competitive jobs and removed from the benefit rolls. Generally, the Social Security Administration disability population is older and more severely disabled than other individuals with whom the rehabilitation agencies work. Failure to rehabilitate more SSA beneficiaries is attributed to the economic disincentives involved. For many beneficiaries, working is not an attractive alternative to retaining their disability benefits and Medicare coverage. Further, many beneficiaries, even if rehabilitated, lack the earning potential to make working an attractive alternative to disability benefits."

Given the population in question, the GAO statement is not unexpected, but we are in favor of giving disabled individuals the opportunity for training and assistance that will encourage their attempts to work. It is our concern that, in part because of how State rehabilitation agencies are now reimbursed, many individuals may not be given an opportunity to attempt rehabilitation. We recommend that the payment procedures be changed to pay State VR agencies for their efforts to rehabilitate disabled individuals, even if the individual does not successfully reenter the labor market. This recommendation is not contained in the DAC report, but is reflective of the law prior to the change in rehabilitation reimbursement procedures enacted in 1981. However, the Secretary of HHS should prescribe regulations setting forth performance standards for the rehabilitation provider to better insure accountability and quality service. An individual who is on the SSDI rolls should have the opportunity to leave the program. He or she should expect a competent rehabilitation evaluation, and if indicated, an appropriate array of rehabilitation services designed to assist the individual to obtain employment, or at a minimum, a better quality of life.

Further, we endorse the Advisory Council's efforts to improve the VR system and support legislative recommendations for the Secretary to purchase VR services directly from the private sector, as well as from public or other non-profit agencies, provided adequate performance standards and protections for the client are formulated and monitored by the Secretary. We feel that with the large number of potential clients, such referrals will not diminish the State VR workload potential and will provide greater opportunities for SSDI beneficiaries. It should be noted that according to SSA, blind SSDI beneficiaries (and possibly others who are not blind) leave the rolls based on their own efforts rather than as a result of rehabilitation services. For instance, the data SSA provided show that in 1984, of the 677 blind SSDI beneficiaries who were terminated under the Continuing Disability Reviews, 255 of those were on the basis of a voluntary report of return to work. In 1983 out of 500 terminations, 200 were based on a voluntary report of a return to work. Statistics for the years 1980 through 1982 reveal a similar pattern. We believe that competition among rehabilitation providers is healthy and will ultimately benefit blind and other disabled persons. In addition, pending further study and demonstration of a vouchered payment system, we recommend that such agencies be paid by SSA and not through a voucher system.

We also endorse the Council's recommendations with reference to VR as follows:

- Congress should require SSA to collect data concerning the characteristics of beneficiaries that State VR agencies accept, serve and rehabilitate and the characteristics of those not served by State VR agencies and the causes therefor.
- Congress should require State VR agencies to consider for VR services every SSA beneficiary who is referred as required by law, and the Department of Education should monitor the State VR agencies to ensure compliance.
- Congress should authorize the Secretary to require that agreements which the Commissioner enters into with State VR agencies for the purpose of providing VR reimbursement payments include a provision requiring State VR agencies to provide SSA beneficiaries with those services that are necessary to achieve and maintain employment.
- Congress should direct SSA to pay for evaluations of DI and SSI beneficiaries whom it refers for VR services.
- Congress should change the reimbursement provisions of the Act to enable SSA to pay for VR services provided during benefit suspension months.
- Congress should mandate that SSA's reimbursements to States be returned to State VR agencies and not to State general funds.
- Congress should extend the benefit continuation provisions that apply to beneficiaries who medically recover while participating in State VR programs to those who medically recover while participating in other VR programs that meet State accreditation standards.
- SSA should communicate and enforce existing sanctions for refusal to participate in VR programs.

- The Secretary should promulgate and enforce regulations that clearly required DDS units to refer for VR services all eligible applicants consistent with SSA standards and must not exclude or limit referrals based on any other criteria.
- SSA should make prompt decisions and payments on VR reimbursement claims.
- SSA should encourage State VR agencies to involve employers and unions in the design and structure of job skills training programs for SSA clients involved in the rehabilitation process.
- SSA should work with the President's Committee on Employment of the Handicapped to involve employers in the establishment of job programs for DI and SSI recipients.
- The President should create a Cabinet-level committee to study and make recommendations designed to facilitate interagency coordination, support and information exchange among the various Federal departments and agencies that administer programs serving people with disabilities.

And for further studies:

- To evaluate the potential for direct involvement of beneficiaries in the selection of rehabilitation providers and in the design of their VR programs.
- To study factors which contributed to the successful employment of former disability beneficiaries who, despite the presence of severe impairments, continue to work until retirement age.
- To test whether funds for the hiring and training of State VR counselor specialists to serve potential SSA clients will be cost-effective and achieve increased acceptance rates, job placements and successful rehabilitations.

Based upon the DAC's recommendations discussed above, and our own suggested improvements, SSDI beneficiaries will be encouraged to participate without fear of loss of benefits while maximizing their work potential.

CONCLUSION

In summary, we support changes in the SSDI program which would improve work incentives, enhance VR services and reimbursement practices and would guarantee to all beneficiaries fairness and equity.

Mr. Chairman, the American Foundation for the Blind stands ready to work with this Subcommittee as you proceed toward legislation with respect to the SSDI program. I would be happy to answer any questions at this time.

Chairman JACOBS. Thank you for your contribution.
Mr. Gorski.

STATEMENT OF ROBERT GORSKI, VICE CHAIR, SUBCOMMITTEE ON SOCIAL SECURITY, NATIONAL COUNCIL ON INDEPENDENT LIVING

Mr. GORSKI. I represent the National Council on Independent Living, a group of 71 independent living programs from across the nation.

In 1977, I was privileged to be on the staff of the Westside Community for Independent Living which is located in West Los Angeles. We spearheaded the initial effort to replace work disincentives with work incentives in the SSI and DI programs.

In 1979, we had to unfortunately accept a political compromise. In order to get an experimental toehold for an SSI benefit spend-down, we had to accept less than we would have liked to have gotten in the DI program. We resolved that once the SSI program would be in order, to address the DI program with our full vigor.

With the 1986 amendments to the SSI program, we have the final fruit of that effort. It is now time to turn our attention to the DI program.

The independent living programs of this country do not want to wait 10 years for effective incentives. We do not have to wait any longer than this year.

There is good legislation in both Houses of Congress right now. Of course, there will be a need for intense discussion on this legislation. There may be a need for compromises, but the basic legislation is there.

Another reason we are hopeful is there is now a today's new, enlightened attitude toward disability and unemployment.

This is embraced by many in the Congress, the administration and the service provider community. There is broad-based bipartisan support to address the DI program, which compared to the SSI program, is much more complicated.

To some extent the Advisory Council report I include as evidence of that new enlightened attitude. The report pulls together an amazing amount of information that is very pertinent.

It asks the kinds of probing questions that need to be asked in this area of public policy. It clearly outlines the essential paradox of cash benefits programs as they were originally structured.

The paradox was that the ability to work for a few months and at less than minimum wage, was the test for which disabled people needed no benefits.

The report is also very insightful in clearly observing that the effect of disability or employment is highly individualized.

To quote from the report, "it is not possible to construct a set of medical and vocational standards that will distinguish perfectly between those who are able to work and those who are not able to work."

So we like the report in its descriptive mode. We depart from our support for the report when it becomes prescriptive and starts to describe how to make things better.

The National Council has two standards for changes in the DI program.

One, work incentives must protect the financial integrity of the system. Two, work incentives must reflect the actual experience of disability and what actually encourages and what discourages disabled people from working.

In belittling the effectiveness of a DI benefits spend-down—and I am not using the phrase, "earnings offset, benefits offset." I am talking about a spend-down. We are interested in having people spend down from dependence to independence. We believe the report perpetuates a narrow-minded straitjacket approach to employment and disability.

The report also reflects a willingness to accept a one-size fits none approach to disability. The key element in the SSI work incentives is the provision for disabled people to flexibly mix earnings, cash benefits, medical coverage and personal care benefits. The importance of this concept is why we accepted, in 1979, the opportunity for an experimental foothold for an SSI benefit spend-down. The intervening years have shown what we claimed for a benefits spend-down is correct. It has helped SSI recipients undertake employment without risks to their health and well-being and has protected the benefits system.

We believe a benefits spend-down can safely be applied to the DI program. This idea of a much feared horde of new beneficiaries is not credible. The idea of a large group of people who are going to stop work, wait 5 months for benefits, and 2 years for Medicare is more than we can foresee. I can't see people finding that kind of prospect tantalizing.

Also, a benefit spend-down is a great way to conserve resources. It saves money by gradually reducing support levels. Because it adds no risk to the taking of employment and does not put a DI beneficiary in jeopardy, it improves the likelihood of being used.

I think——

Chairman JACOBS. Mr. Gorski, I hate to tell you this. The 5-minute rule means your time has expired.

Mr. GORSKI. May I have 15 seconds?

Chairman JACOBS. Thirty seconds.

Mr. GORSKI. Thank you.

I think the problem of the reporting can be illuminated by some of the language used in the report. I will use one example. The idea—the report—to quote the report, it said that disabled people—people who are disabled and working present a public policy dilemma. The fact I am a disabled person and working is no problem to me or anybody in this country.

The problem or the public policy dilemma we face is the fact that programs have been structured around invalid attitudes toward disability. We need new work incentives that accurately reflect what disabled people actually experience.

[The statement of Mr. Gorski follows:]

STATEMENT OF ROBERT GORSKI, NATIONAL COUNCIL ON INDEPENDENT LIVING

I am here representing the National Council on Independent Living, which is a membership association of 71 independent living programs throughout the nation. These programs provide services to disabled people living in their own homes; the services are delivered and managed by people with disabilities; and persons with disabilities constitute a majority on each member's Board of Directors. Many member programs have been providing services for 10 years and longer.

Our members have been keenly interested in work incentives for SSI recipients and DI beneficiaries and which meet two rigorous standards for effectiveness. One, they must protect the financial integrity of the Social Security system. Two, they must reflect how people with disabilities actually live and what actually encourages and discourages them from employment.

In 1977 I was privileged to be on the staff of the Westside Center for Independent Living - located in West Los Angeles - which spearheaded the initial legislative effort to replace work disincentives with work incentives in the SSI and DI programs. In 1979 we reluctantly accepted the necessity of a political compromise: In order to get new, effective SSI work incentives we had to be content with advocating for new DI work incentives which we knew would be of only minimal help to DI beneficiaries. Once the SSI program was in good working order, we resolved to ourselves, we would address DI with full vigor.

The 1986 amendments to the SSI program are the final fruit of that compromise. Thus, counting from 1977, it took 10 years to achieve SSI work incentives that met our standards of (1) protecting financial integrity for the program and (2) reflecting the actual experience of disability.

Independent Living programs do not want to wait 10 more years for effective DI work incentives. There is no need to wait any longer than this year. First of all, there is good legislation in each House of Congress. Of course, there are numerous details that merit intense discussion; there will be some alterations, and some compromises. But the basic legislation is there.

Second, a new and enlightened attitude toward disability and employment is very broadly embraced today by many in Congress the Administration and the service provider community. There is sufficient, broadly based, bipartisan support for addressing the DI program, which, compared to the SSI program, is larger and more complex.

To some extent, I include the report of the Advisory Council as evidence of embracing a new and enlightened attitude toward disability and employment. This is the extent to which the report is "descriptive"; for, it pulls together a amazing body of pertinent facts and information. It asks many of the probing questions that need to be asked for public discussion. It clearly outlines the central paradox of cash benefits programs as originally structured: The ability to work for a few months and at less than minimum wage was the test for revealing which disabled people needed no cash, medical, care assistance - AT ALL.

The report is insightful in cogently observing that the effect of disability on employability is highly individualized: Even two people with similar disabilities usually have greatly differing experiences with disability. Moreover, the Report accurately observes that it is "not possible to construct a set of medical and vocational standards that will distinguish perfectly between those who are able to work and those who are not able to work."

Nevertheless, where the Report becomes "prescriptive" regarding work incentives, the National Council on Independent Living finds that it does not embody an enlightened attitude to disability. And here we find the Report does not meet our standards for (1) protecting the system and (2) reflecting the actual experience of disability.

In belittling the effectiveness of a DI benefits spend down, the Report perpetuates a narrow-minded, straight jacket approach to disability and employment. The resulting constellation of work incentives reflects a willingness to accept a "one-size-fits-none" approach.

Instead, a benefits spend down combined with a rising co-share for Medicare and personal care programs is the best way to individualize assistance programs. This tailors work incentives to the disabled person's individual experiences, limitations, and opportunities. Some DI beneficiaries find it only possible to work intermittently - for example, some who have multiple sclerosis, which often flares up and then abates. For other beneficiaries, it is possible to work continuously, but at a series of part-time jobs which bring in a highly fluctuating income. Work incentives are needed that fit what people actually need.

The key element in the SSI work incentives is the provision for disabled people to flexibly mix earnings, cash benefits, medical coverage, and personal care benefits. To gain an experimental foothold for this principal in the SSI program is why, in 1979, we gave in on DI work incentives. The intervening years have shown that what we claimed for a benefits spend down was correct. It has helped SSI recipients undertake employment without risk to their health and well-being and it has protected the benefits system.

A benefits spend down can be safely applied to the DI program. That this will open the gates to a flood of new beneficiaries with substantial incomes is not to be feared. It did not happen in the SSI program, and, furthermore, there is less likelihood of it occurring in the DI program due to wait periods. The much-feared horde of new beneficiaries with substantial earnings must all stop work and wait 5 months for DI benefits and TWO YEARS for Medicare. I submit that very few disabled people with substantial earnings will find this prospect tantalizing.

The National Council focuses on having DI beneficiaries work off the program, or at least to reduce their use of the program's resources as much as possible. We support a benefits spend down because we want beneficiaries to spend down from dependence and toward independence.

Let me underscore, again, that protecting the financial integrity of the system is of paramount importance to us. We know from our own experience how necessary Social Security programs are to the health and well-being of persons with disabilities who lack the resources to meet their daily living needs.

A benefits spend down is a great way to conserve program resources. It saves money by gradually reducing support levels. Because it adds no additional risk to undertaking employment, and does not put a DI beneficiary who uses this work incentive in any jeopardy, it improves its likelihood of being utilized. This was not the case with the DI work incentives which we accepted in 1979. We as disabled people knew that they would do little good; we knew they would be little used and bring no appreciable savings to the system.

These work incentives featured (1) a time-limited Period of Extended Eligibility of 15 consecutive months triggered by low earnings following the completion of the Trial Work Period of 9 cumulative months, and (2) a time-limited period of extended Medicare coverage which commenced sometime after the end of the Trial Work Period, and which could or could not overlap the Extended Period of Eligibility - depending on circumstances.

We did not think much of these provisions because there were still "one-size-fits-none" work incentives. They were also so complicated as to be incomprehensible to most people.

This brings me to the issue of simplicity. The Advisory Council report observes repeatedly that if work incentives are not easily understandable DI beneficiaries will avoid using them and Social Security staff and other providers will not be able to explain them. We believe this is very true. Furthermore, the Advisory Council report recommends that work incentives be marketed as "an important element" of the DI program. Again, we agree and further say that this is another reason why work incentives must be simple in structure and operation. It is a valid statement that you can not market something unless you can describe it in simple terms.

A DI benefits spend down is an easy-to-understand, and highly marketable work incentive. It appeals to our natural intuition for varying what we need from others in inverse proportion with what we can provide for ourselves. Secondly, it makes work incentives in the DI program consistent with the current SSI program, which is universally seen as being far more understandable now that before.

It is simple, marketable, easy to understand. It saves money. It protects the system. It actually works. In a DI benefits spend down Congress has a safe bet to score a positive hit.

So why didn't the Advisory Council recommend a benefits spend down? Why did they see things so differently? I cannot see inside the heads of the Council members, but certain passages in the Report will, I believe, illuminate an~~swers to these~~ questions. Several times, the report cites beneficiaries' "unfounded fears" as a reason for avoiding work activity. At one point, beneficiaries who work "on a sustained basis at a level just below SGA" are labeled "residual." More generally, the Report describes beneficiaries who are working as "working in spite (my emphasis) of their impairments."

Finally, the report claims that working beneficiaries "present a difficult dilemma for public policy."

These passages suggest an attitude toward disability and employment that is not encouraging. It is one that appears to be blind to the fact that a decision not to work derives from prudent economic analysis. It appears to rigidly assert that disabled people who do not conform to preconceived notions about work are oddities, and maybe troublemakers.

Furthermore, to work "in spite of a disability" is a phrase used throughout our society by people who have low expectations for what disabled people can do. It ignores the fact that disabled people who work are simply normal people who have disabilities and who also work.

Finally, because I or any other disabled person works is not a difficult dilemma or any sort of problem for anybody. If there is a problem somewhere, it is in the mind of the beholder who looks at me working and sees an aberration from the traditional picture of disability.

If there is a "public policy dilemma" involving work incentives, it is not due to disabled people working, but to the basing of cash benefits programs on invalid assumptions about disability. The Report of the Advisory Council is flawed in its "prescriptions" for DI work incentives because it fails to accurately embody the experience of disability.

Chairman JACOBS. Mr. Wilson.

STATEMENT OF MICHAEL WILSON, MEMBER, PUBLIC POLICY COMMITTEE, NATIONAL MENTAL HEALTH ASSOCIATION

Mr. WILSON. Mr. Chairman, I am Michael Wilson. I am here today to discuss my own experience of how the Social Security disability insurance program has actually resulted in disincentives for me to go back to work.

I am speaking on behalf of the National Mental Health Association and as a member of their Public Policy Committee. I am currently employed by the Center for Persons with Disabilities, Inc., in Tallahassee, Fla., where I work with the protection and advocacy agency for the mentally ill.

Although many who know me personally would disagree, I consider myself highly fortunate because of the opportunity I have had in the work force. I have had the privilege of having a job that relates to my illness and to the problems of people who have my illness.

Before I got this job, though, I did have a much more difficult time.

There are many areas here today that we are discussing that are relevant to people with my disability and the work disincentive. In particular, we come across the SSI situation. While we were happy to see the improvements made by section 1619 last year, there are many disabled Americans with mental illness in this country whose benefit income is just a little bit higher than SSI.

They work just enough to have a minimum benefit, so what they got was $20 more to get them to the minimum SSDI level. What this section did was for those people who were on SSI with no significant work history, it created an opportunity for them to go into the work force, still receive part of their check, and maintain funding of the medical benefits while for a large number of the SSDI population, it created a situation where you could have had a work history and you still had the disincentive to go back to work.

I think I could best summarize—you have my statement on record—how difficult it was for me. Consider that I tried to get on SSDI three times between 1978 and 1984, and in 1981, after spending 17 months in a State hospital, I was turned down for SSDI on the basis that the time was spent in an HRS residential facility in my State and was therefore "residential."

I bring this up because I hear people trying to say that people want to be disabled to receive SSDI benefits. I challenge anybody to go spend 17 months in a State hospital so they can get disability benefits. It stretches the imagination to say the least. I have had some good jobs in my life, and if I had been approved for DI in 1981, my benefit check would have been much higher than it was when I was approved in 1984, because there was that 10-year period where I worked jobs in between.

The other thing I think needs to be pointed out here is this is really a common sense issue. I see somebody who is disabled with my particular form of disability as struggling to get adequate care. One of the benefits of Social Security disability income for me was that I got Medicare.

One of the disadvantages was that that only meant I could go to a psychiatrist five times a year. The new improvements to Medicare enacted last year and under the catastrophic health care bill would allow me to have much better benefits. But even so, the disincentives are still there.

While I am extremely fortunate to have a well-paying job, most of my friends are not. I am truly unique in that category. I am not so much here testifying for me today as I am for them. How many people do you know in the world who have $360 a month income on disability, have enough money in the bank to set themselves up in a new well-paying job, have the clothing expenses, the transportation expenses, everything else involved in going back into the work force? Not very many.

The other reason for making these changes is that we should keep things simple. The thing that the insurance benefits did for me is to help regulate my illness. They helped me to get good care. They helped me to be able to function along at a healthier pace so while those benefits I got from becoming disabled were making me better, there was no incentive for me to get back on to the work force.

The reason for keeping those benefits is just as simple. It doesn't take a genius to know that if you maintain good health it costs less than not being able to maintain good health because of lack of insurance. Thank you.

[The prepared statement and attachment follow:]

STATEMENT OF MICHAEL WILSON, NATIONAL MENTAL HEALTH ASSOCIATION

Mr. Chairman, Members of the Committee, my name is Mike Wilson, and I am here today to discuss from my own experience how the Social Security Disability Insurance (SSDI) program has resulted in disincentives for me and other mental health consumers to return to work. I am speaking on behalf of the National Mental Health Association and as a member of the NMHA Public Policy Committee. NMHA is a citizen's advocacy organization concerned about all aspects of mental health and mental illness.

I am currently employed by the Florida Protection and Advocacy Agency, where I assist individuals with mental illness to understand and exercise their right to be free from abuse and neglect while in a mental health facility. Although many who know my history and know me personally would disagree, I consider myself highly fortunate because of the opportunity I have had in the work force. I have the privilege of having a job that relates to my illness and to the problems of people who have my illness. Before I got this job, I had a much more difficult time.

I fall into a category that was not considered when the improvements were made last year for the SSI (Supplemental Security Income) population. I am among a large number of disabled Americans who have some minimal level of work history that is sufficient to qualify me for SSDI. In order to compensate for the fact that the amount I received under SSDI was still under the "minimum income," I was given a small amount of SSI that would allow me to make $20.00 a month more than those only on SSI. When the new work incentive rules went into effect last year, a person who was on SSI and had no work history whatsoever was actually able to go back to work and not lose his benefits. He could keep part of his check. However, I, who have some work history, am not able to get a job and keep part of my paycheck, except under the very limited trial work period.

My work history since 1976 is a good example of why I and other individuals with mental disabilities who have had some work experience would benefit if similar changes were made to the SSDI program as have been made to the SSI program.

I had a good job in 1976. I worked for two years as a maintenance chief in K Mart but I lost the job because of my illness.

I made three attempts to get SSDI before I finally was accepted at the end of 1984. I started to receive support from SSI at the same time. I had great difficulty getting benefits, despite my illness. In 1981, for example, I was disallowed despite a 17-month stay in a residential facility. If I had been found disabled at that time, my SSDI checks since then would have been much larger.

After losing my "good job" at K Mart, I worked on and off. I had odd jobs for short periods of time, such as a farm store clerk and a sales clerk. Because of this, I was denied SSDI benefits.

In January of this year I got my present job, at the Protection and Advocacy agency. My trial work period will end at the end of this year. Despite my cover myself. I pay $400 a month for my prescriptions. Since I know that there are many, many consumers who do not make that income that I presently make, I am painfully aware of the lack of incentive that they have to go back to work. If an individual loses his job after having worked past the trial period, there is little incentive for him to try working again since after 3 months on the job, he will lose his medicare and SSDI benefits.

Until I got this job, only minimum wage jobs were available to me. This is typical of individuals with a severe mental disability. I've been continually at risk of losing all or part of my benefits for taking minimum wage jobs that provide little stability. I and many others like me need cash benefits to help us to overcome our disability so that we are able to work. The instability of these jobs (they generally don't last very long for anyone whether or not they have a mental illness) and the low earnings, make them unattractive, especially since health benefits, which pay for prescriptions and physician services, would also be lost.

Now that I am working, at a very good job, I will continue to receive Medicare coverage for a short time. Unfortunately, Medicare's limit on coverage of mental illness and prescriptions are so restrictive, that they are nearly useless. Medicare has been useful in allowing me to choose a better psychiatrist, but I have been limited to only five visits a year. I understand that this Committee is responsible for legislation passed last year which will make Medicare significantly more helpful to mentally disabled people. Under these changes, I will have unlimited access to my physician for medication, presciptions and management, as well as additional benefits. I also understand that the catastrophic health care bill now in conference may help with this problem also, as apparently there will be a significant improvement in Medicare's coverage of presciptive drugs.

Another problem is the cost of prescriptions, which for me (and others in my situation) typically costs between four and six hundred dollars a month.

Health care coverage is a major problem for mentally ill people trying to return to work. Due to major deficits across the country for mental health coverage, we experience major obstacles in getting insurance coverage through the job. Many of us quit altogether, because of being unable to meet medical expenses related to mental illness. Clearly, this financial pressure only add to the stress and burden of the illness we are trying to overcome. Before I got my present job, this more typical scenario was my life!

Very few individuals are willing to take the risk of giving up benefits that keep them healthy in order to take a job that would give them the esteem of a paycheck. The additional income that they get from the paycheck would be used to make up for the benefits they lost under medicaid. They stand to lose more financially by going back to work!

It would be much cheaper to allow us to return to work and to keep our benefits, than it is to deny us benefits if we try to work, because we just can't manage otherwise. The difficulties I experienced in getting my benefits made me very cautious about risking losing them again. We need to allow mentally disabled individuals to continue to contribute to the workforce in a steady, productive way.

While we are being welcomed back into the workforce as productive employees, it is happening only on a small scale. The stigma against people with disabilities is pervasive, and because of that, I urge you to consider the following:

Allow a person on SSDI to maintain his benefits or some of his check to help him to return to the workplace on a permanent basis. By allowing an individual to keep his benefits, you keep a productive employee in society who can contribute both financially to the economic growth of this country and to the destigmatization of disabled people.

Giving a disabled person a part of his SSDI check for a length of time is a reasonable request. No one who has been on SSDI with a total income of $360 per month for a couple of years could possibly have enough money in the bank to make the costly transfer into a well-paying job. There are clothing expenses, transportation, and often relocation costs which must be considered. Continued access to health insurance coverage, especially the improved Medicare package, is also essential since many individuals will not be able to get this coverage through a group policy.

We look to the Social Security System to empower us, not to contribute to the discrimination that we face every day of our lives. The NMHA is urging the Committee to act this year on legislation to give SSDI beneficiaries a work incentive program comparable to the Section 1619 program in SSI. Congressmen Bartlett, Levin and others have just introduced HR 4680, and I hope you can pass it so that disabled SSDI beneficiaries can have hope that they can be productive members of society and be proud of their contribution.

Thank you.

Man battles mental illness — as a patient and an advocate

By JUDY HILL
Tribune Staff Writer

CLEARWATER — Mike Wilson has spent most of his life fighting manic-depression, a serious mental illness that has hospitalized him more than 100 times.

During the past 15 years, Wilson also has been fighting another battle — this one on behalf of his fellow psychiatric patients — first as a volunteer at the local level and now as a paid professional.

"I was tailor-made for this job," said Wilson, a client advocate at the Advocacy Center for Persons With Disabilities, based in Tallahassee. "It's as if they designed it for me."

The Advocacy Center is a 2-year-old, non-profit agency designed to protect and serve as an advocate for people with all types of disabilities.

Wilson's job is to investigate and resolve claims of abuse or neglect filed by mental health consumers.

The husky 38-year-old former St. Petersburg resident certainly is qualified to challenge the public mental health system.

In the past 28 years, he has been confined to public psychiatric hospitals — mostly in Florida — 115 times.

He took up volunteer advocacy about 15 years ago as self-treatment for his own illness. He accepted the paid position with the center in January.

The articulate Wilson suffers from manic-depression, a biochemical brain disorder often characterized by unusual mood swings, a condition often treatable with medications.

In his case, the condition does not usually bring the euphoric highs experienced by many manic-depressives — mostly just the depression, which has led him to several suicide attempts and 26 shock treatments.

The disorder first struck Wilson when he was a boy in New York and has shrouded his life with failures, including job problems and a broken marriage.

In Clearwater recently to speak at a dinner for the Mental Health Association of Pinellas, Wilson, hazel eyes clouding, said: "My life was a mess. I hadn't been a success at anything."

Wilson's passion as an advocate also promoted him to some national prominence.

He serves on the board of directors of the National Mental Health Consumers Association. He also testified in 1987 before the U.S. Senate Judiciary Committee then studying the Fair Housing Act of 1987 that, if passed, would make it illegal to discriminate against the physically and emotionally disabled in housing issues. The act is still in committee.

Since his first hospitalization as a child, Wilson said, he has seen dramatic changes in the mental health delivery system.

But he said that there is still much to be done.

A shortage of money for treatment, the stigma of mental illness, and discrimination in housing and jobs are just a few critical areas, he said.

One of Wilson's biggest disappointment is that mental illness, which strikes one out of four Americans, does not have a higher priority on the national agenda.

He looks with pride and envy at the recent outpouring of support for deaf students at Gallaudet College in Washington, who demonstrated for — and won — a deaf president for the institution that serves the hearing-impaired.

Wilson said he thinks his new job — though not without personal hazards because of his illness — gives him a wonderful opportunity to affect the system.

"It is a risk, but it's such a satisfying experience just to have a shot at making things better for other people," he said.

But Wilson quickly added that he does not want to be held up as a mental health "success."

"I don't consider myself a success story," he said. "I consider myself someone who has learned to live with my illness and am doing the best that I can."

THE TAMPA TRIBUNE
Friday, May 13, 1988

Chairman Jacobs. The committee thanks the panel for your considerations. We will call the next panel.

The Council of State Administrators of Vocational Rehabilitation, represented by Joseph Snyder; the National Association of Rehabilitation Professionals in the Private Sector, represented by its president, Bill Roberts; the National Association of Disability Examiners, represented by Dave Tschetter.

STATEMENT OF JOSEPH A. SNYDER, EXECUTIVE DIRECTOR, PENNSYLVANIA OFFICE OF VOCATIONAL REHABILITATION, REPRESENTING THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

Mr. Snyder. Thank you for the opportunity to appear and submit our written statements.

Like most of the other witnesses, I will try to highlight some of our written testimony.

I represent the Council of State Administrators of Vocational Rehabilitation, made up of directors of the State agencies that provide vocational rehabilitation services to eligible persons in this country.

We are very encouraged that the Disability Advisory Council has made some sound and practical recommendations which, if implemented, would improve the SSA program. Those include having SSA reimburse the States for evaluating SSDI and SSI beneficiaries who are referred by the State disability determination units.

We are also encouraged that the DAC has embraced certain kinds of work incentive concepts, including an increase in the level of substantial gainful activity. We are troubled that some of their recommendations display a lack of understanding of both the rehabilitation act and its provisions, and what we do at the State level in vocational rehabilitation.

For example, basic eligibility requirements are ignored by the Disability Advisory Council when it refers to a refusal to serve DI and SSI beneficiaries. I find the opposite is true.

Back in 1981, which wasn't that long ago, under the former SSA beneficiary rehabilitation program, State agencies got about $124 million in SSA funds to serve eligible SSI and SSDI beneficiaries. This was about 14.5 percent of that year's vocational rehabilitation Federal appropriation.

Last year, only $25 million was reimbursed to the States. Under the current program, this amounts to only 2 percent of the Federal allocation for State rehabilitation agencies. Despite this loss of funds, approximately 10 percent of the people who are rehabilitated into employment by the State agencies are SSDI and SSI beneficiaries.

To me, that shows we are indeed working with SSI and SSDI beneficiaries, even though we get far less funding for that service.

We are concerned with one important aspect of the recommendation that SSA should purchase rehabilitation services directly from private sector VR facilities. I certainly have no quarrel and we have no quarrel with the private sector, and quite frankly believe in a public/private partnership because we share the same goals and also share the same principles that disabled people are a great potential asset.

Disabled people have a tremendous amount to offer to this country. Quite simply, we want to make sure that the public and the private agencies play by the same rules.

Bill Cosby, back when he was a standup comedian, used to have a routine where he did a coin flip and started the Revolutionary War. The British lost the flip and that meant they had to wear red uniforms and walk in straight lines. Sometimes we in the States feel like the British; we are disadvantaged because we have to play by different rules in the open.

And really, the expenditure of public money for the provision of rehabilitation services requires strict adherence to the principles of client participation and client rights embodied in the Rehabilitation Act. We are very troubled by the potential loss of those client rights. With those assurances, we think SSA could well pursue the avenue for service delivery.

I was heartened to hear Congressman Bartlett with his proposals and listen to the discussion of his proposals, and urge that you carefully consider those proposals because Congress has over the years enacted various work-incentive provisions in the Social Security Act for the purpose of removing disincentives to work and creating incentives to work.

All too often the Social Security Administration fails to recognize that in the often long, step-by-step processes involved when people with disabilities embark on employment, quite frankly their focus tends to be on the bottom line, which is the removal of people from the SSI and SSDI rolls.

In forming public policy, the entire government needs to have a broader goal, a goal that recognizes the benefits that come from SSI beneficiaries and people who begin to engage in part-time employment for the first time in their life. The opportunities are there for them to be part of this society, to be part of what we take for granted, the work environment every day.

The final comments that I would make is, we agree with the Disability Advisory Council that the SGA level should be adjusted to reflect the average wage growth since it was last increased and should be indexed to such growth in future years and the monthly earnings amount for trial work should be increased from $75 to the SGA level.

We strongly believe in order for the work-incentive provisions to work effectively, the Social Security Administration must abandon its focus on only seeing success when a person is removed from the SSDI or SSI status. Benefits can be a bridge to independence and I think people deserve that opportunity.

Thank you for the chance to present my remarks.

[The statement of Mr. Snyder follows:]

STATEMENT OF J.A. SNYDER, EXECUTIVE DIRECTOR, PENNSYLVANIA OFFICE OF VOCATIONAL REHABILITATTON, ON BEHALF OF THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

The Council of State Administrators of Vocational Rehabilitation is comprised of the chief administrators of the public rehabilitation agencies providing services to eligible persons with disabilities in the fifty states, the District of Columbia, and our Nation's territories.

These agencies are the state partners in the State-Federal Program of Rehabilitation Services for eligible persons with mental and/or physical disabilities, including eligible recipients of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), as authorized by the Rehabilitation Act of 1973, P.L. 93-112, as amended.

These State agencies participate in the Social Security Administration's (SSA) Vocational Rehabilitation Program, created by the Congress in 1981.

Through the SSA/VR Program, the SSA reimburses the States for the cost of "successfully" providing rehabilitation services to SSDI beneficiaries and SSI recipients. The definition of "success" for the SSA/VR Program, and the criteria for reimbursement, is employment at the level of "substantial gainful activity" for nine months.

Last year, the States received approximately $25 million in reimbursements under this Program.

Prior to FY 1982, under the previous SSA Beneficiary Rehabilitation Program (BRP), State Rehabilitation Agencies were provided direct grants to be used for the provision of rehabilitation services to SSDI and SSI beneficiares.

In FY 1981, the last year of the BRP's operation, the States received approximately $124 million under the BRP Program.

As the organization representing our Nation's primary providers of vocational rehabilitation services to people with disabilities, the members of the Council of State Administrators of Vocational Rehabilitation were enthusiastic that the Congress, in 1986, authorized the creation of a Social Security Disability Advisory Council (DAC).

The mission of the DAC was to study, among other things, the effectiveness of the Social Security Vocational Rehabilitation Programs, and various Work Incentive efforts to enhance the employability of SSDI and SSI beneficiaries.

Now, upon reviewing the Final Report of the Disability Advisory

Council (DAC), our reactions are mixed.

We are encouraged that the DAC has made certain sound and practical recommendations which, if implemented, would improve the current SSA/VR Program. Among others, these include having the SSA reimburse the States for the provision of evaluation services to SSDI and SSI beneficiares who are referred for services by State Disability Determination Services Units.

We are also encouraged that the DAC has embraced certain "work incentive" concepts, including, importantly, an increase in the level of substantial gainful activity.

Taken together, improvements in the SSA/VR Program and in the Work Incentive Provisions will, we believe, significantly enhance prospects for the employability of eligible SSDI and SSI beneficiaries.

We are troubled, however, that with some of its recommendations and rationale, the DAC displays a lack of understanding of the Rehabilitation Act and its provisions.

For example, basic "eligibility" requirements in the Rehabilitation Act are ignored by the DAC, when it states that it is "concerned that refusal to serve DI and SSI beneficiaries is a violation of the law and blatantly discriminates against a segment of the population with severe disabilities."

We are also concerned that the DAC recommends a direct funding link between Federal SSA dollars and private rehabilitation services providers, without even mentioning whether or not people with disabilities served under publicly-funded, private-sector activities should be afforded basic protections of client participation and appeal -- protections afforded in statute to those individuals served by Programs under the Rehabilitation Act.

The remaining testimony will discuss in more detail two specific programmatic areas studied by the Disability Advisory Council: the SSA/Vocational Rehabilitation Program; and the SSA Title II and Title XVI Work Incentive Provisions.

THE SSA/VOCATIONAL REHABILITATION PROGRAM

In its Report, the DAC unfortunately leaves many misleading impressions about the involvement of State Rehabilitation Agencies in the SSA/Vocational Rehabilitation Program, and in the rehabilitation of **eligible** SSDI and SSI beneficiares.

To best understand this involvement, one must first understand three factors:

1. That the definition of "eligibiity" to receive SSDI or SSI benefits differs vastly from the "eligiblity" requirements for Rehabilitacion Services.

> **Under the Social Security Act**, "disability" is defined as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or is expected to last for a continuous period of not less than 12 months."
>
> In addition, the term "any substantial gainful activity" refers to an individual's ability to perform any job, anywhere in the economy.
>
> **Under the Rehabilitation Act of 1973**, an individual's eligibility is determined by (a) the presense of a physical or mental disability that constitutes a substantial handicap to employment and (2) a reasonable expectation based on the availability of resources that the individual can benefit from vocational rehabilitation in terms of employability.

From these basic differences, it is important to realize that the effectiveness and appropriateness of the provision of vocational rehabilitation services to SSDI and SSI beneficiaries should be judged and determined on a case-by-case basis, and that broad generalizations, such as those made in the DAC report, should be avoided.

2. In 1981, the Administration hastily implemented the Continuing Disability Reviews provision in the Social Security Act, requiring the "benefit status" of each SSDI and SSI beneficiary to be reviewed for continued eligibility -- a policy which resulted in approximately 500,000 individuals being purged from the DI and SSI rolls.

While many thousands of individuals who were purged from the rolls were wrongly denied benefits, it can be argued that those who remained on the rolls after this purge were more severely disabled, older, and, in general, less likely to be eligible when referred for vocational rehabilitation services.

The "purging of the rolls" also created an intense climate of fear among individuals with disabilities in this Nation. Potentially thousands of individuals who could have been referred for rehabilitation services were afraid of showing any inclination to work, for fear of losing their disability benefits.

3. As previously mentioned, in 1981, under the former SSA Beneficiary Rehabilitation Program, State Rehabilitation Agencies received approximately $124 million in SSA funds to service eligible SSDI and SSI beneficiaries. This sum amounts to 14.5 percent of that year's total Federal allocation to State Vocational Rehabilitation Agencies.

In 1987, approximately $25 million was reimbursed to the States under the SSA/VR Program, a sum which amounts to 2 percent of the total Federal allocation for State Rehabilitation Agencies.

Despite this loss of funds, approximately ten percent of people rehabilitated into employment by State Rehabilitation Agencies are SSDI and SSI beneficiares.

From these facts, it is clear that State Agencies are serving eligible SSDI beneficiaries and SSI recipients in numbers far exceeding that which could be served if only SSA funds were so used.

DAC PROPOSALS AFFECTING THE SSA/VR PROGRAM

Within this context, the CSAVR is encouraged that the Disability Advisory Council (DAC) has embraced several practical proposals, which, if enacted into law or implemented by the SSA, would significantly improve the operation of the SSA/VR Program.

REIMBURSEMENTS SHOULD BE MADE FOR PROVIDING EVALUATION SERVICES

The DAC recommends that the Congress should direct SSA to pay for the evaluation of SSDI and SSI beneficiaries whom it refers for services.

The Council agrees.

In reimbursing State Agencies for the provision of evaluation services to all those individuals whom SSA refers for rehabilitation services, there would be an expansion of the pool of eligible SSDI and SSI beneficiaries who are brought into the Rehabilitation system.

SSA SHOULD IMPROVE ITS REIMBURSEMENT CLAIMS PROCESS

The DAC appropriately recognizes that improvement is needed in SSA's basic administration of the SSA/VR Program, and recommends that "SSA should make prompt decisions and payments on VR reimbursement claims."

In May, 1987, the DAC found that there was a backlog of over 5,000 such claims.

This backlog slows the flow of dollars to State Rehabilitation Agencies, thus causing the delay of the provision of rehabilitation services to eligible individuals with disabilities. Obviously, a continued backlog of reimbursement claims impedes the ability of State Agencies to provide rehabilitation services.

The CSAVR urges the Subcommittee to monitor the SSA's efforts to ensure the timely processing of these claims.

SSA SHOULD PROVIDE REIMBURSEMENT DIRECTLY TO STATE AGENCIES

The statutory language establishing the SSA/VR Program stipulates only that SSA reimburse the "States" for the successful provision of Rehabilitation Services.

While no State Vocational Rehabilitation Agency has yet lost these reimbursement dollars to its State's general fund, such challenges have occured and may one day be successful.

The Subcommittee is urged to act upon this recommendation, and statutorily clarify that reimbursements under the SSA/VR Program are to be made directly to the State Vocational Rehabilitation Agency.

In addition, the CSAVR supports the DAC recommendations that urge the Congress to change the reimbursement provisions of the Social Security Act to (1) "enable SSA to pay for VR services provided during benefit suspension months," and (2) to provide that the "benefit continuation provisions" applicable to persons who "medically recover" are extended to those who are participating in private, accredited, Rehabilitation Programs.

DIRECT FUNDING TO PUBLIC AND PRIVATE ENTITIES, OTHER THAN STATE VOCATIONAL REHABILITATION AGENCIES

The CSAVR is most concerned with one important aspect of the DAC recommendation that the SSA should purchase rehabilitation services "directly from private sector VR facilities, Federal Agencies and State agencies other than State VR agenceies."

While, in general, the stimulation of more rehabilitation is a positive goal, we fervently believe that **the expenditure of public monies for the provision of these services requires a strict adherance to the principles of client participation and rights embodied in the Rehabilitation Act.**

Without these principles intact and in operation, public monies should not be spent to fund the provision of rehabilitation services.

With, and only with, these assurances for client participation rights, should the SSA pursue this avenue of service delivery.

WORK INCENTIVE PROVISIONS

For the Federal Government to be successful in encouraging SSDI and SSI beneficiaries to return to productivity and work, and/or to become more independent, it is important that the Social Security Act contain provisions to ease the transition from benefit status to employment and independence.

To assist in this process, and to complement the positive impact of the SSA/VR Program, the Congress has over the years enacted various "Work Incentive" provisions in the Social Security Act, for the purpose of removing disincentives to work, or creating incentives to work.

Before discussing the DAC recommendations in this area, it is important to stress that all too often, the Social Security Administration fails to fully recognize that an often long, step-by-step process is involved when an individual with a severe disability embarks on a transition from dependency to employment.

Quite frankly, the SSA's narrow focus is on its bottom line -- the removal of indiviudals from the SSDI and SSI rolls.

The SSA seems, most often, to administer its SSA/VR Programs and the Work Incentives Provisions with only this goal in mind.

In forming public policy, the Congress, and the entire Federal Government, including the SSA, must have a broader goal -- a goal which recognizes, for example, the benefits which accrue when an SSI recipient begins to engage in part-time employment for the first time in their life.

While such part-time employment may not be at a level which enables the indiviudals to be self-sufficient and no longer dependent upon SSI, it does have a positive impact on the Nation, the economy, and most certainly, on the person who is working. Indeed, such part-time employment may lead, in time, to greater independence and eventual self-sufficiency.

We believe that the the SSA must embrace this goal in its administration of the SSA/VR Program and the work incentive provisions.

Specifically, the Disability Advisory Council makes a number of positive recommendations to enhance the current Work Incentive Provisions in the Social Security Act.

These include the following:

1. The Substantial Gainful Activity (SGA) level should be adjusted to "reflect the average wage growth since the SGA was last increased," and that it should be indexed to such growth in future years.

> 2. The monthly earnings amount that counts toward the trial work period should be increased from $75 to the SGA level.

At present, the SGA level is so unreasonably low that individuals receiving SSDI benefits are discouraged from working or from seeking rehabilitation services, for fear of crossing the meager SGA level and thus, losing benefits.

A higher trial work period closer to the SGA level would encourage SSDI beneficiaries to engage in trial work activities and to seek rehabilitation services and part-time and full-time employment.

In addition to the recommendations of the DAC, the CSAVR is encouraged by legislation introduced by Congressman Steve Bartlett, of Texas, that would expand the Section 1619 work incentive provisions to SSDI beneficiares.

The CSAVR strongly believes that in order for the SSA/VR Program and the Work Incentive Provisions to work effectively, the Social Security Administration must abandon its focus of only seeing success when a individual is removed from SSDI or SSI benefit status.

The goals of these SSA Programs and provisions are a part of the larger goal of the Congress and the Federal Government -- to move people from dependency to independence and productivity.

In designing SSA Programs and policies towards this end, we must recognize that the transition from dependency to independence is often a long process, which often involves long periods of part-time work supported by continued disability and health benefits.

The implementation and/or enactment of the above-mentioned positive recommendations of the Disability Advisory Council, and the SSA's focus on them as a high priority, would assist many thousands of individuals in their efforts to become independent, productive, tax-paying citizens.

Chairman JACOBS. Mr. Roberts.

STATEMENT OF BILL ROBERTS, PRESIDENT, NATIONAL ASSOCIATION OF REHABILITATION PROFESSIONALS IN THE PRIVATE SECTOR

Mr. ROBERTS. Thank you, Mr. Chairman, and distinguished members of the committee. I want to thank you for allowing NARPPS to present testimony to you today, and I would like to rise for a minute to recognize possibly those in the audience that are hearing impaired. I do not sign, but if you will give me your name and address, I will provide you with a written copy of my testimony. For those who are sight impaired, if you will give me your name and address, I will provide you with a braille copy of my testimony.

My name is Bill Roberts and I am president of the National Association of Rehabilitation Professionals in the Private Sector. NARPPS appreciates the recognition by the private sector, by the Social Security Administration and the Disability Advisory Council, and for allowing the private-for-profit sector to submit proposals to the Social Security Administration for returning SSDI and SSI recipient to work.

The NARPPS membership represents approximately 12,000 rehabilitation practitioners in more than 2,500 business entities throughout the United States. The private sector rehabilitation service delivery capacity is growing, as evidenced by the growth of NARPPS during the past 2 years, which from April of 1986 when I took the office of president, we had 1,200 members and at present we have 2,500 members.

NARPPS membership is governed by standards, ethics and peer review, and when a member applies for membership they have to sign that they will abide by those standards, ethics and peer review.

NARPPS membership at the present time is being asked to approve service delivery standards. We hope the service delivery standards will be adopted during June of 1988.

NARPPS membership is made up of rehabilitation professionals from both the private and public sector. The private sector rehabilitation professional works in various work settings. Again, it is a new concept, and we feel these new work settings should be now recognized as part of the rehabilitation service delivery system in the United States.

This delivery system is effective and consistent with developing outreach programs to the client and to the community. Concurrent studies during 1987 of the private sector conducted in Florida, Minnesota, and by the Menninger Foundation found that 60 to 70 percent of injured workers in the worker's compensation systems throughout the United States were being returned to work. That is a great difference from the 1 percent leaving the rolls of SSDI.

A rehabilitation unit in the State of New York has a pilot program that utilizes the private sector rehabilitation service delivery model. NARPPS feels that private sector initiatives can be utilized to increase the number of SSDI and SSI recipients leaving the disability rolls and returning to work.

We are happy to hear that Congressman Steve Bartlett has introduced H.R. 4680, that will remove the disincentives for the SSDI recipient when returning to work. I am recommending to the NARPPS Board of Directors that we support H.R. 4680.

NARPPS supports the legislative recommendations, administrative recommendations and issues deserving further study contained in the report by the Council. As president of NARPPS, I have been working to improve the working relationship with the Social Security Administration, Department of Labor, Department of Education, who I met with this morning, and the State vocational rehabilitation agencies.

NARPPS supports more efficient and effective use of the public and private rehabilitation service provider in delivering rehabilitation services to the SSDI and the SSI recipient. NARPPS supports the client rights of the SSDI and SSI recipient.

All NARPPS members who are awarded demonstration projects by the Social Security Administration or any other Federal, State agency are willing to guarantee client rights in the same manner and scope as the client rights are guaranteed by the State vocational rehabilitation agency.

NARPPS knows that there are profound differences between the self-perception of disabled persons who are working versus the self-perceptions of disabled persons who are not working. The disabled persons that are working feel better about life than those disabled persons that are not working feel about life.

NARPPS feels that there should be an increased effort to identify disabled Americans whatever the cause of the disability who have a potential to return to some type of productive work and/or independent living.

NARPPS recommends and supports the idea that new ground should be broken in regard to the delivery of rehabilitation services to Americans with disabilities.

NARPPS feels there should be linkage and coordination of existing State, Federal rehabilitation programs and the private sector rehabilitation service providers in the United States. NARPPS supports and welcomes the measurement of outcomes of all rehabilitation service providers in both the public and private sector in the United States.

It is a waste of human resource and a tragedy when only 1 percent of the SSI recipients are being returned to work. AS the report indicates in quotation markets, they are only being denied the means with which to improve the quality of their lives.

It will be a great day for Americans with disabilities when the public and private rehabilitation resources can be united in assisting disabled Americans in returning to work.

Thank you, Mr. Chairman, for your time this morning.

Chairman JACOBS. Thank you.

[An attachment to the prepared statement follows:]

Standards and Ethics

National Association of Rehabilitation Professionals in the Private Sector

Preamble

NARPPS members recognize the uniqueness of the private rehabilitation field. The conduct of members of a professional organization must be ethical at all times. NARPPS recognizes the free enterprise system and believes that fair competition encourages the development of quality services to both the client and referral source.

Professional Conduct by Discipline

The member is obligated to maintain technical competency at such a level that the recipient receives the highest quality of services that the member's discipline is capable of offering. The implementation of a rehabilitation plan for a client is a multidisciplinary effort. NARPPS members will conduct themselves in interdisciplinary relationships in such a way as to facilitate the contribution of all specialists involved for maximum benefit of the recipient of services and to bring credit to each discipline.

Minimal Standards for Service Delivery

Standards shall apply to those persons who are providing the services.

The services and submission of reports shall be provided in a timely fashion and shall respond to the purpose of the referral and include recommendations, if appropriate. All reports shall reflect an objective, independent opinion based on factual determinations within the provider's area of expertise and discipline. The reports of services and findings shall be distributed to appropriate parties and in compliance with all applicable legal regulations.

The member shall render only those services that the member is competent and qualified to perform.

The member has an obligation to withdraw from a professional relationship if it is believed that the participation will result in violation of the ethical standards of his/her professional discipline.

There shall be a stated rationale for the provision of services to be rendered to the client in the form of an identified objective or purpose.

The member shall refuse to participate in practices which are inconsistent with the standards established by regulatory bodies regarding the delivery of services to clients.

Members will adhere to all tenets of confidentiality.

At the time of initial referral, the member has the responsibility for identifying to the referral source and to the client what services are to be provided and practices to be conducted. This shall include the identification, as well as the clarification, of services that are available by that member.

Professional Education, Training and Experience

NARPPS supports the principle of accreditation of member rehabilitation companies on a voluntary basis.

NARPPS considers the following standards to be the minimum requirements for a Rehabilitation Practitioner:

A. **Professional Rehabilitation Practitioner**

1. Holder of a Masters or Doctorate degree in health-support services from an accredited institution, plus one year of experience in vocational rehabilitation or physical rehabilitation. At least one year shall have been spent in the rehabilitation of disabling conditions and/or disease; or
2. Holder of a Baccalaureate degree in health-support services from an accredited institution, plus two years of experience in vocational rehabilitation or physical rehabilitation. At least one year shall have been spent in the rehabilitation of disabling conditions and/or diseases; or
3. Diploma in Nursing from an accredited institution plus a current R.N. license, plus three years of experience in physical rehabilitation or vocational rehabilitation. At least one year shall have been spent in the rehabilitation of disabling conditions and/or diseases; or
4. Holder of any Baccalaureate degree other than listed in No. 2 above from an institution, accredited plus three years of experience in vocational rehabilitation. At least two years shall have been spent in the rehabilitation of disabling conditions and/or diseases.

B. **Associate Rehabilitation Practitioner**

Holder of an Associate degree or high school diploma, plus continuing education and five years experience in vocational rehabilitation, including counseling, evaluation and direct case services. Three of the five years shall have been spent in the rehabilitation of disabling conditions and/or diseases.

C. **Rehabilitation Intern**

An individual who meets the minimum education requirements but does not meet the experiential requirements must be supervised by a professional rehabilitation practitioner. The intern shall provide the name of the professional rehabilitation practitioner under whose direct supervision he/she will work. The supervisor will function as the primary case manager.

Advocacy

Advocacy is a term used when referring to the act of pleading the cause or coming to the aid of another. NARPPS members respect the integrity and interest of the people and groups with whom they work. With regard to disabled persons, advocacy takes into account such issues as the legal rights of handicapped people to achieve integration into the social, cultural and economic life of the general community. The role of the NARPPS member as an advocate is to protect and promote the welfare of disabled persons to maximize control over circumstances that interfere with their obtaining vocational independence. When there is a conflict of interest between the disabled client and the NARPPS member's employing party, the member must clarify the nature and direction of his/her loyalty and responsibilities and keep all parties informed of that commitment. NARPPS supports legislation that provides for services and care for the disabled.

Testimony

NARPPS recognizes that a rehabilitation practitioner has a responsibility, when requested, to provide objective testimony.

Rehabilitation Practitioners provide services within the legal system and, in addition to providing primary care rehabilitation services, are called upon to testify as to facts of which they have knowledge or to render a professional opinion on rehabilitation questions or disability factors affecting an individual.

The testimony of a rehabilitation practitioner should be limited to the specific fields of expertise of that individual as demonstrated by training, education and experience. The extent of the practitioner's training, education and experience needed to testify is determined by the legal jurisdiction in which the practitioner is testifying.

It is also permissible for a rehabilitation practitioner to render an expert opinion and answer questions about a disabled or handicapped individual that has been evaluated either in person or hypothetically.

Confidentiality

The purpose of confidentiality is to safeguard information that is obtained in the course of practice. Disclosures of information are restricted to what is necessary, relevent and verifiable with respect to the client's right to privacy. When a third party is involved, the key to confidentiality, when considering personal or confidential information, is to make certain that the client is aware, from the outset, that the delivery of service is being observed by the third party. Professional files, reports and records shall be maintained under conditions of security and provision will be made for their destruction when appropriate.

Business Practices

Individuals and/or organizations in private sector rehabilitation should adhere to all applicable standards and practices common to the general business community. In addition, they should give special attention to and adhere to the following specific points:

1. Members will adhere to all applicable federal, state and local laws establishing and regulating business practices.
2. Members will not misrepresent themselves, their duties or credentials.
3. Members should carry professional liability insurance for the protection of themselves and affected third parties.
4. Rehabilitation Practitioners shall not engage in claims practices as such are defined under the statutes and legal precedents in their respective jurisdictions.
5. It is to be encouraged that any discussion and comments or criticism directed toward a fellow Rehabilitation Practitioner or organization shall be positive and/or constructive.
6. Competitive advertising should be factually accurate and shall avoid exaggerated claims as to costs and results.
7. When asked to comment on cases being actively managed by another Rehabilitation Practitioner and/or organization, the reviewer shall make every reasonable effort to conduct an in-person evaluation before rendering his conclusion.
8. A Rehabilitation Practitioner member will not promise or offer services or results he cannot deliver or has reason to believe he cannot provide.
9. A member is not to solicit referrals either directly or indirectly by offering money or gifts other than *de minimis* gifts to a referral source.
10. When recruiting an employee, members should not falsely promise benefits, employment advancement or salaries which they know or have reason to know that they cannot meet.
11. No Rehabilitation Practitioner or organization shall effectuate or participate in the wrongful removal of professional rehabilitation files or other materials upon the initiation of new employment.
12. Rehabilitation Practitioners shall not enter into fee arrangements that would be likely to create conflicts of interest or influence their testimony in claims cases. Rehabilitation Practitioners shall advise the referral source/payor of its fee structure in advance of the rendering of any services and shall also furnish, upon request, detailed accurate time records.
13. Member referral sources working for member organizations or individuals shall pay invoices in accordance with normal payment practices.

Standards Compliance Review Board

The function of the Standards Compliance Review Board will be to investigate and rule on alleged infraction of the approved standards and ethics of NARPPS members. The Standards Compliance Review Board will consist of the following:

a. Rehabilitation Counselor
b. Rehabilitation Nurse
c. Vocational Evaluator
d. Placement Specialist
e. Insurance Claimsperson or Buyer
f. Private Practitioner (general)
g. Company Administrator

Adopted November 1981.

NOTE:

ALL COMPLAINTS SHOULD BE FILED BY MAILING THEM IN AN ENVELOPED MARKED:
Personal and Confidential
Chairperson of the Standards Compliance Review Board
National Association of Rehabilitation Professionals in the Private Sector
P.O. Box 218, Blue Jay, CA 92317

STATEMENT OF DAVID TSCHETTER, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS, ACCOMPANIED BY MICHAEL BRENNAN, LEGISLATIVE DIRECTOR

Mr. TSCHETTER. My name is Dave Tschetter. I am president of the National Association of Disability Examiners. Our association is made up of professionals involved in the Social Security disability program.

Along with me today is Mr. Mike Brennan from the Maryland determination services, who serves as our legislative director.

The hearing today is very important to our association because of our commitment to be involved in the issue of returning disability recipients back into the work force. State agencies which administer the program in various States have a real interest in the rehabilitation process. This is enhanced by the fact several of our agencies are part of the State vocational rehabilitation program.

We would like to acknowledge the Disability Advisory Council for their work and also commend Congress and the administration for their serious approach to the issue of returning very able citizens back into the national work force.

The basic comments which I have in reference to the Disability Advisory Council report, I would like to summarize and submit our written statement for the record.

Basically, the National Association of Disability examiners supports many things that have already been mentioned this morning. We support an escalation of the SGA level for title II to the same level as that provided to blind individuals.

In addition, we would support the escalation of the $75 services situation for a trial work period, also to the level which would be accommodated for SGA.

The Disability Advisory Council discussed briefly section 1619 of the program. During our testimony before the Council, it was our recommendation that consideration be given to expanding this program to include those receiving disability benefits under title II of the Social Security Act.

The most recent data on section 1619 shows that it is an excellent incentive for individuals who are returning to the work force.

Expansion of the 1619 provision to all disability recipients would ensure all people are treated equal under the Social Security disability program. Because of the 1619 program being limited to SSI recipients, there can be an inconsistency when child beneficiaries under title XVI apply for title II benefits.

The National Association of Disability Examiners also agrees with the Council's statement there needs to be a coordinated effort between all government agencies and the resources of the private sector in addressing the issue of work incentives.

Addressing the issue of effectiveness of State vocational rehabilitation agencies is difficult. The Council reported, pointed out some problems experienced by government providers of vocational rehabilitation services. One item which we as an association needs to be stated is that employment is only one of the many roles which vocational rehabilitation agencies provide.

These agencies also provide services for the several disabled and blind including such things as assistance in independent living and various services to blind individuals from age birth through death. As an association, we believe that additional contracting out of services could result in additional fragmented services to citizens and their respective States.

Another concern which our association has when considering any changes in the existing structure of the SSA and vocational rehabilitation would be the protection of individual clients' civil rights under the Rehabilitation Act of 1973. The current steps of referral which are now used could be enhanced through upgrading in the system by which the beneficiaries are referred and the types of referrals which are done.

The data, when a disability examiner completes a data sheet at the time of a final decision, this sheet contains a considerable amount of information on medical diagnoses, medical diary, work history and educational background. This type of information could be sued as a base for data in reference to those who are referred to vocational rehabilitation.

The data obtained from the vocational rehabilitation agencies on successful closures should be relayed back to the State agencies. This information would assist in developing vocational rehabilitation screening criteria. This would help in identifying individuals who are potential beneficiaries who may be able to return to the work force.

The Disability Advisory Council also made several different recommendations in reference to the disability determination process which are included in our written record.

I would like again to thank the subcommittee for allowing us to present our views on the report submitted to Congress in view of the disability program and its relationship to vocational rehabilitation.

We as an association believe, even without any changes the members of our association, are involved in a very unique and basically effective government disability program. The public has been well served by the current system, but we look forward to working with Congress, the administration and the public in developing the best possible program for citizens for which it was intended.

Thank you very much for the opportunity to present our views at this hearing.

Chairman JACOBS. Thank you, Mr. Tschetter.

[The statement of Mr. Tschetter follows:]

STATEMENT OF THE NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

It is an honor to be able to speak to you today in reference to the findings of the Disability Advisory Council report and the findings of the General Accounting Office. My name is David Tschetter, and I am President of the National Association of Disability Examiners. Our association is made up of professionals involved in the Social Security Disability Program. Along with my duties as President of the National Association of Disability Examiners, I am also employed by the South Dakota Disability Determination Services. I have been employed by the South Dakota DDS since March 1974, and am currently working as a Quality Assurance Specialist and as one of South Dakota's Disability Hearings Officers.

The National Association of Disability Examiners has had the opportunity in the past to present testimony before this committee on various aspects of the Disability Program. The hearing today is very important to our association because of our commitment to be involved in the issue of returning disability recipients back into the work force. The State Agencies which administer the program in various states have a real interest in the rehabilitation process. This position is enchanced by the fact that several of the agencies are part of their states Vocational Rehabilitation Program. As an association, we have had the opportunity to follow the development of the Disability Advisory Council's report for the past one and one-half years and have presented testimony at three of their field hearings and one of their regular meetings. We would like to acknowledge the Disability Advisory Council for their work and also commend Congress and the Administration for their serious approach to the issue of returning very able citizens back into the national work force.

I would like to direct our comments today on several issues which the Disability Advisory Council has discussed in their findings, and I would like to address these within the framework of how our association views some of the recommendations. We have outlined our comments within the following topics:

1) Work incentives and disincentives within the SSDI program.
2) Changes recommended in the studies being addressed.
3) Changes recommended in the administrative framework for vocational rehabilitation.
4) The adequacy of existing information concerning the work potential of SSDI beneficiaries.

The development of work incentives is a very recent issue. While the program has always had a direct link between rehabilitation and disability, it has only been in more recent years that specific programs have been developed to enhance the concept of returning beneficiaries back into the work force. Our association supports the Disability Advisory Council findings that many of the existing programs designed as work incentives for the SSDI and SSI beneficiary could be strengthened through a better understanding of how each of the individual programs works. Our association would like to state our support of the Council's recommendation that the Substantial Gainful Activity level should be raised. Our recommendation would be that the level should be consistent with the levels established for individuals who are blind. We are also supportive of raising the current level of $75 used to determine services for Trial Work Period months increasing to the same level as that which is set for Substantial Gainful Activity. These types of measures would assure that more beneficiaries would be willing to attempt to work and also would create a consistent application of rules which reflect attempts to work

The Disability Advisory Council disucssed the Section 1619 program. During our testimony before the Council, it was our recommendation that consideration be given to expanding this program to include those receiving disability benefits under Title II of the Social Security Act. The most recent data on the 1619 section shows that it is an excellent incentive for individuals who are returning to the work force. The number of individuals who have qualified for the 1619 provision has increased greatly since it was fully implemented. The number of people who are receiving benefits could be reduced if this program were expanded to include all disability recipients. Expansion of the 1619 provisions to all disability recipients would also insure that all people are treated equally. Because of the 1619 program being limited to SSI recipients, there can be an inconsistency when child beneficiaries under Title XVI apply for benefits under Title II. Once again, a consistent treatment of all applicants is needed.

The National Association of Disability Examiners also agrees with the Council's statement that there needs to be a coordinated effort between all government agencies and the resource of the private sector in addressing the issue of work incentives.

Addressing the issue of the effectiveness of the State Vocational Rehabilitation agencies is difficult. The Council's report pointed out some problems which are experienced by government providers of Vocational Rehabilitation services. One item which we as an association feel needs to be stated is that employment is only one of many roles which Vocational Rehabilitation Agencies provide. These agencies also provide services for the severly disabled and blind including such things as assistance for independent living, and various services to blind individuals from age 0 through death. As an association, we believe that additional contracting out of services could result in additional fragmented service to citizens of their respective states. Another concern which our association has when considering any changes in the existing structure of the SSA and Vocational Rehabilitation would be the protection of the individual client's Civil Rights under the Rehabilitation Act of 1973. The current steps of referral which are now used could be enhanced through upgrading in the system by which beneficiaries are referred and the type of referrals which are done.

The last area which we would like to comment on is in reference to the current data which is available on the success or failure of Vocational Rehabilitation referrals. When a Disability Examiner completes a data sheet at the time of a final decision, this sheet contains a considerable amount of information on medical diagnosis, medical diaries, work history and educational background. This type of information could be used as a base for data in reference to those who are referred to vocational rehabilitation. The data obtained from the vocational rehabilitation agencies on successful closures should be relayed back to the state agencies. This information would assist in developing vocational rehabilitation screening criteria, and this would help in identifying individuals who are potential beneficiaries who may be able to return to the work force.

The Disability Advisory Council also made several comments pertaining to the Disability Determination Services which we would like to address. These include: The variance in allowance rates from state to state, an inadequately controlled Federal-State arrangement for administering the DI and SSDI programs, the lack of specificity in the rules used for determining disability and an appeals process which fails to encourage the development of complete and correct evidence early in the process. Our association would like to comment briefly on each of these concerns.

We believe that the variance in allowance rate between states is more of a problem which is related to the demographics of the area and not as much due to the state agency involved. One suggestion, which is heard often by people in the disability field, is that these types of concerns could be controlled with an increased review of decisions. Our association does not concur totally with this type of statement for two reasons. Prior to 1975, the determinations completed by the state agencies had a 100% review by Central Office; and there were still considerable variances in the allowance rates of the states, and the other reason why this would not work is the variance in the individuals who review claims including both the review specialist and the medical professionals. Our recommendation to assist in bridging the gap in allowance rates would be for a more unified training of both the disability examiners and medical professionals at all levels.

The existing State-Federal arrangement which is used for administering the Disability Program has been the subject of several discussions by different groups. When we presented testimony before your Sub-Committee in the Fall of 1987, our concerns dealt with the apparent onesidedness of the present arrangement. The current assessments which are used to determine the productivity of an individual State Agency are based on total staff which can vary from state to state. In addition, several specialists such as Quality Assurance Reviewers, Medical Relations Officers and Disability Hearings Officers are being utilized as Disability Examiners and are not being used in their fields of speciality. We feel that additional consideration should be given to both the State and Federal sides of the current agreement. The greatest area where this is a concern is in the area of spending. Within the current agreement, the states have very limited say in the spending and levels of spending which are dictated to them.

The National Association of Disability Examiners would concur on most points with the Council's statement that there is not enough specifity of criteria in the adjudicative process. The evaluation of those individuals who meet or equal a specific listings is not the question in this area. These rules are very specific and need only to have periodic updates as medical science changes. The major difficulty arises in the evaluation of those individuals who's capacity reduces their ability to do a full range of work activity. The Council did study the utilization of work evaluations in the adjudication of disability claims. While these are somewhat impractical in how to define skills and job traits for disability determining purposes and study of the utilization of modern functional capacity assessments would be one of our association's recommendations. While the success of such utilization is not known, the study of this type of adjudication tool would be appropriate.

The final area of concern, which we would like to comment on regarding the Council's recommendations, is in refernce to Administrative Law Judges reversals. It is our feeling that an expansion of face-to-face reviews at an earlier level in the adjudicative process would decrease the number of reversals once a claim reaches hearings level. This type of action would strengthen the initial and reconsideration level of the program, as well as, cut back on the extensive backlog of hearings claims. In this same spirit, our assocation would support the establishment of a Social Security Court to review appeals of claims.

I would like to thank the Sub-committee for allowing us to present our views on the report submitted to Congress in review of the Disability Program and it's relationship to Vocational Rehabilitation. We believe that even without change the members of our association are involved in a very unique and basically effective government disability program. The public has been well served by the current system, but we look forward to working with Congress, the Administration and the public in developing the best possible program for the citizens for which it was intended. Thank you very much for the opportunity to present our views at this Hearing.

Chairman JACOBS. What do you think the expense would be to raise the SGA of the nonblind disabled to the level accorded the blind?

Mr. TSCHETTER. First of all, I believe most of the individuals we are talking about are already those that are involved in being on disability and that stay away from returning to work because of either the limited jobs that are available or that type of situation, which really restricts them.

So the actual expense, we as an association do not have the resources to really determine that. But one of the feelings that we have is that many of these individuals, while they would still be drawing some types of benefits, also would be paying back into the system, where at this particular time, because of the limitations, they avoid working and are not paying back the system.

Chairman JACOBS. It is probably a figure people are going to want to know. I suppose it is calculable and we will have it in due course.

Mr. Snyder, I received a letter in April from a Ms. Nancy Coffey from Oklahoma, who is the administrator, has an administrative officer, I guess, in the vocational rehabilitation program in Oklahoma. She proposes financial incentives to counselors on the basis of rehabilitation efforts which are successful.

Does that make any sense to you?

Mr. SNYDER. I think that one of the things we at the State level always try to look at is what kind of incentives we would have to make our employees feel better about the job they are doing and to recognize those that do a particularly good job.

Generally I think in Government those incentives are never financial because of the approach to the public person, the public dollar, but I do think States already recognize those counselors who do a better job rehabilitating different categories of individuals.

I come from Pennsylvania, and we try to recognize our counselors that do exceptional jobs with different categories of people. I think that offering incentives would be sort of gilding the lilly to us at the State level.

I am not necessarily speaking for all other State directors, but we look at our job as rehabilitation for people who are disabled and our reward comes from that rehabilitation and from that individual being more independent and more integrated into the work force.

I don't necessarily think that we have to pay extra bonuses to people to do that job. We have a system where turnover amongst counselors is very low because of the reward that is intrinsic in the job.

Chairman JACOBS. Mr. Roberts, and the rest of the panel, we thank you for your contribution to the hearing.

The next panel involves the National Federation of the Blind, Marc Maurer, the Paralyzed Veterans of America, Dennis Smurr; and the National Committee To Preserve Social Security and Medicare, Mr. Lessard.

Mr. Maurer, I believe you are the first witness. Please proceed.

STATEMENT OF MARC MAURER, PRESIDENT, NATIONAL FEDERATION OF THE BLIND

Mr. **Maurer**. Thank you, Mr. Chairman.

I am Marc Maurer, president of the National Federation of the Blind. I will summarize a written statement which I have already submitted for the record.

The National Federation of the Blind has a historical and strong, very substantial interest in the disability insurance and SSI programs. The vast majority of our members are blind.

We know firsthand the human and economic need for improved work incentives in these programs. We have been telling Congress about it for years, and you have responded to some extent, and favorably.

Now the Advisory Council proposes that you should take back work incentives for the blind in the SSDI program, giving fewer blind people the chance to have earnings and to be productive. That approach is wrong.

We take the opportunity to endorse the opposite view as expressed in H.R. 1997, introduced by Mr. Lehman of Florida. There should be more incentive for the blind to work, not less.

Consider the blind person 69 or older. Those who can work have the incentive to do so. There is no limitation on their earnings. Then for blind people who have attained age 65 but are not yet 69, there is an earnings setoff. So benefits are at least not abruptly terminated for those who decided to work. But even that incentive, the earnings set-off, is withdrawn when we come to the blind of working age.

This is where the substantial gainful activity concept, SGA, comes into play. It is an earnings limitation, pure and simple. That is the only, and counterproductive, effect of applying SGA To the blind.

In the case of disabilities other than blindness, SGA is useful. It is a measurement tool to help determine the disability. Blindness, however, is defined and immediately determinable.

We know too that there are certain social and economic consequences that accompany blindness, and most blind people experience them. Being outside of the work force is almost always a part of it.

Blindness is a great disadvantage in work place acceptance. Over 70 percent of the blind of working age are for the most part unemployed. Most blind people of working age already draw disability insurance or SSI. There could only be an advantage to them and to the Social Security system to remove the limitations on earnings.

I should note that earnings for the blind under SSI have never been limited by applying SGA. Blindness is defined in title XVI as it is in title II. The problem with applying SGA to the blind under disability insurance is once again that it only serves as a limitation on earnings, nothing more.

This mixes a welfare or a means-test approach with an insurance program. But SSDI is actually insurance, not welfare. Its benefits are payable to the rich, even the very rich, and the poor alike. Wealth, or lack thereof, has no bearing on eligibility. Only earnings are penalized. This is not done to limit income, as I have said already. It is only done to limit work for the blind. That approach is counterproductive.

The principles of insurance, not welfare, should apply equally to the blind throughout the disability insurance program, to the rich and the poor alike, to the working and nonworking blind alike. There should be no different standard. Work, in fact, should be encouraged.

This brings me to the point of rehabilitation. We do support the Disability Advisory Council's recommendation for rehabilitation services to be provided by public or private agencies other than State vocational rehabilitation agencies.

The exclusive use of State VR agencies for rehabilitation of beneficiaries is probably more a matter of historical accident than anything else. For a long time when the practice of paying for rehabilitation with Social Security funds first started, these were essentially the only agencies available. Besides there was already an administrative structure and a Federal/State partnership in place. But the exclusive use of State agencies has not been advantageous either for the program or for its beneficiaries.

I am aware of some State agencies that have actually required blind beneficiaries to pay all or a great portion of the costs of their rehabilitation. This is because some States have adopted economic means tests for all of their VR clients. They apply these restrictions to beneficiaries as well.

So by buying into the State agency VR system, Social Security is also buying into all of its built-in restrictions. The result is that rehabilitations do not occur in all too many cases, and no wonder, when beneficiaries have to pay for services they cannot afford. If they could afford it, they would not need the services.

We support a choice in using other agencies, public or private, Mr. Chairman, in this regard.

We support and call to your attention H.R. 4273, introduced by Representative Harold Ford of Tennessee. Mr. Ford's bill is the legislative solution we have been looking for in rehabilitation for the blind.

Under that bill, each blind beneficiary of either SSDI or SSI would be free to choose his or her preferred agency for rehabilitation. The individual too would be encouraged to select and design his or her own program and goals with the assistance of the agency of choice. We use such principles in higher education, vocational education and even to a great extent in medical assistance. It works there and it will work in rehabilitation as well.

Mr. Chairman, thank you for the opportunity to present these views in response to the Disability Advisory Council's final report.

As we have in the past, we will continue to assist in the development of any legislation you may consider. We urge you particularly to include in that consideration the two bills I have mentioned.

Mr. Chairman, I thank you, and we will be glad to respond to any questions.

[The prepared statement follows:]

BEFORE THE SUBCOMMITTEE ON SOCIAL SECURITY

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

WASHINGTON, D. C.

STATEMENT OF THE

NATIONAL FEDERATION OF THE BLIND

MARC MAURER, PRESIDENT

MAY 26, 1988

Mr. Chairman, I am Marc Maurer. I am President of the National Federation of the Blind (NFB). My address is 1800 Johnson Street, Baltimore, Maryland 21230. Thank you for offering me this opportunity to present the views of the NFB in response to the Final Report of the Social Security Disability Advisory Council.

There are over fifty thousand blind people who are members of the National Federation of the Blind. We have a local chapter of the Federation in almost every sizable population area in this country and a state affiliate in all states and the District of Columbia. In short, Mr. Chairman, NFB is organized and active in all parts of the United States.

By virtue of its size and scope NFB represents and speaks for the blind as a collective body. The positions we express in hearings such as these are the result of the democratic process of debate and decision making. The supreme authority of the Federation is its national convention, which occurs annually. During the convention we openly debate (and approve or disapprove) a number of policy resolutions. In this manner the Federation is truly the blind speaking for themselves. It is not simply an organization speaking for the blind. All of our elected officers and the vast majority of our members are blind. For these reasons the NFB is widely known as the voice of the nation's blind.

You have before you a final *Report of the Disability Advisory Council*. In this statement I hope to provide you with a basis for policy making in response to this report. My comments will deal with the experience of blind people in the Social Security programs of Disability Insurance (SSDI) and Supplemental Security Income (SSI) and with our experience in seeking training and job placement assistance from vocational rehabilitation.

Every day, Mr. Chairman, I work with blind people all over this country who are struggling to provide for themselves. I meet with blind people in a constant stream. I see them at meetings. I receive and read their mail each day. I talk with blind people on the telephone every day, as well. In the course of a single year as President of the National Federation of the Blind I believe that I have personal contact with tens of thousands of blind people. In addition, I have the benefit of my own personal experience. I have been blind all of my life, so I have had extensive, direct experiences with both the Social Security and vocational rehabilitation systems.

I must say, Mr. Chairman, with all due respect to the individuals who have served on this Advisory Council, my knowledge of blindness and blind people does not lead me generally to form the same conclusions as those they have included in their report. In the first place, the report glosses over the most essential differences between the SSDI and SSI programs. The distinctive characteristics of these programs are not to be treated so lightly. Secondly, the report carries the implicit and false assumption that blindness and the other disabilities are essentially the same and should be governed by the same eligibility provisions. Finally, the report erroneously concludes that more beneficiaries will go to work if eligibility requirements of the programs are not so generous.

The respective purposes of SSDI and SSI are quite different. One is insurance; the other is welfare. This major difference has significant implications for policy decisions about work incentives and rehabilitation.

In the SSI program, Mr. Chairman, we are dealing with providing a monthly cash (subsistence level) grant to people who have been largely outside of the work force. By law, SSI recipients have virtually nonexistent resources. For about 76,000 blind people who have not had the opportunity to work very much, SSI provides their only form of income support and maintenance. It is a vital program. Some, but only modest, income is permitted as an incentive to work. We are not satisfied that the work incentives (particularly income allowance provisions of SSI) are strong enough, but we do understand the essential nature of this program as being welfare. That is quite different from insurance, even social insurance.

SSDI is insurance. It should not be treated as (or operated as) welfare. Being without resources (or being poor) is not a condition of eligibility for SSDI. The income and assets of a spouse are also not considered. The result is that even very rich people can qualify for--and receive--SSDI checks and the Medicare eligibility that attaches as an additional benefit. The fact that the rich and the poor alike can receive SSDI checks simply attests to the nature of this program as insurance; something that is quite different from income maintenance or welfare. Furthermore, a person can not be eligible for SSDI unless he or she has paid in enough to earn the benefits.

These comments are not intended to be critical of either program. Both serve a particular clientele. The report implies that the clientele of SSDI (on the one hand) and SSI (on the other hand) are essentially the same. But the failure to draw the distinction between welfare and insurance has led the panel to make false conclusions about the type of work incentives that should be applied in either program. I will comment further on these work incentive matters after explaining the nature of blindness as a particular and unique condition.

Blindness is a defined and detectable physical condition with predictable economic and social consequences that flow from it. Blindness is, in fact, the only physical impairment that is actually defined in the Social Security Act. Moreover, blindness can be determined (for the most part quite reliably) by an ophthalmological examination. These facts are important to understand in evaluating the validity of applying the Substantial Gainful Activity (SGA) concept.

SGA is generally a measurement tool that is used to define disabilities other than blindness. Thus, in Social Security terminology, a person is "not disabled" if he or she has demonstrated an ability to engage in (or is actually engaging in) SGA. On the other hand, the person is "determined to be under a disability" if he or she cannot perform SGA.

In blindness cases, however, SGA measurements tell us nothing about the existence (or absence) of disability. The disability in these cases is determined by applying the definition in the Act. The only effect of the SGA measurement in SSDI blindness cases is to limit work activity of blind persons. That in our view is a totally counterproductive use of the SGA concept.

In SSI blindness cases, on the other hand, SGA is not applied. Income of blind persons eligible for SSI is, of course, limited by income restrictions of SSI unrelated to the definition of disability. But a measurement of "Substantial Gainful Activity" in blind SSI cases is not a factor whatsoever. That is an entirely appropriate way to handle the determination of blindness.

The fact is, that as the Social Security Act accurately recognizes, blindness exists as a particular physical condition regardless of SGA. Now we know, Mr. Chairman, that there are certain economic and social consequences that accompany the condition of blindness in all but exceptional cases. The use of the SGA concept in SSDI blindness cases seriously adds to and aggravates these consequences. That is why we have long favored legislation (such as H. R. 1997 by Mr. Lehman of Florida) which would remove SGA as an earnings limitation in SSDI blindness cases. Once again, SGA is not an earnings limitation (and never has been such) in SSI blindness cases.

Blindness as we still experience it today has profoundly adverse social and economic consequences. Therefore, the purpose of disability insurance should be to offset these consequences insofar as possible. The social attitudes about blindness are full of myths and misconceptions. As a group, the blind face an incredibly devastating set of artificial impediments when they seek to enter and compete in the labor force. The blind are not just viewed as unemployed. We are usually considered unemployable.

To be sure, the blind pay a heavy price for this erroneous labeling. For example, most people agree that over seventy percent of the employable blind population is either unemployed or underemployed. If before blindness an individual had an income of, say, fifteen thousand dollars annually (not an uncommon income for sighted individuals), and if after blindness that same individual finds employment at $8,500.00 annually (not at all an uncommon experience for the blind), he or she will still not be eligible to continue receiving disability insurance benefits despite the fact that a substantial loss of income has occurred.

More succinctly, the blind are now being asked not only to suffer the indignity of being cast aside in competition for jobs and social opportunities, but we are also required to pay in terms of cold cash for our second-class status. The social attitudes about blindness which have traditionally prevented us from assuming the more responsible positions and holding the more lucrative jobs in the labor force have been fostered by society as a whole, not just by the blind members of society. In fact, these attitudes have not principally been fostered by the blind at all. Therefore it is equitable for us to propose that everyone should share in carrying the financial burden imposed on us by these social attitudes--a burden which we now bear alone.

A second and equally devastating set of economic consequences facing the blind is the result of the Social Security system itself. I refer here to the disincentive factor which inhibits the initiative of any blind person who is naturally concerned about some degree of long-range economic security. The economic realities are these: under existing law, if an individual becomes blind and ceases to engage in "substantial gainful activity," he or she will likely be eligible to draw disability insurance. The individual has every incentive to remain unemployed and not return to work at all. Why? In the first place, he or she is probably not an expert in the law. The law is complex, and the talk of allowed earnings, trial work periods, definitions of "substantial gainful activity" and the like is confusing and not generally conducive to an attempt to make new beginnings. Furthermore, if the individual actually goes to work and (after a specified trial work period) is earning somewhere in the neighborhood of $700.00 per month, benefits will be terminated abruptly. The individual and his or her dependents may be receiving over $1,500.00 per month, the current family maximum. So the individual with only modest earnings of $800.00 or $900.00 per month (or even more) is penalized for having tried to become self-supporting.

Besides all of these complexities, it is conceivable under present law, depending on one's interpretation, that the individual may become blind, go back to work, lose his job, and then be found ineligible ever to receive disability insurance payments again. By going back to work the individual has demonstrated that his blindness does not prevent him from engaging in "substantial gainful activity." If on the other hand, he or she is willing to settle down and draw disability insurance without any attempted work activity at all, the beneficiary can securely rest in the knowledge that the checks will continue on a regular basis, month after month, year after year.

Place yourself in the position of a blind person considering possible employment. Remember that, including dependents' benefits, the family income from Social Security may exceed $1,500.00 per month. I know a number of blind people who (believing in the work ethic) would accept employment offering gross wages at somewhat less than their possible Social Security income, but they must also consider deductions for income and Social Security taxes, as well as a variety of expenses related to their work. Commonly a blind person finds it necessary to employ a reader or driver, and these expenses lower the take-home pay even more. Facing such circumstances, can a blind person afford to take a job at the risk of economic security? Some think they can, but many have found that they simply cannot. Beyond that, we cannot assume that a job will be available for most beneficiaries.

Mr. Lehman's bill at least proposes to offset these adverse economic consequences by providing Social Security benefits to blind persons who have performed a certain amount of covered work. The basis upon which it should be adopted is the broader social benefit which would result if an entire segment of the population whose talents are now underutilized were to be made fully productive. Under this bill the blind beneficiary of disability insurance would know that he or she could count on a monthly insurance payment. It would not be jeopardized by attempted work. The blind person is better off (and society generally is better off) for the person to be productive instead of idle--working instead of sitting at home.

What a promising future there would be with adoption of this legislation, which would usher in an era of confidence and hope and bring down the curtain on despair and discouragement. Today it is rare to find an applicant for disability insurance benefits who has not encountered much anxiety and grief in attempting to gain entitlement to the benefits earned through work. Sometimes the period of decision extends for more than a year, during which there is much correspondence and telephoning, not to mention contacts with one's Senators or Representatives in Congress. This should not be; and adoption of Mr. Lehman's bill will substantially eliminate all of the complexities, mix-ups, and disqualifications which create the delays and resulting disincentives.

Mr. Lehman's bill boldly asks that a special effort be made to eliminate (insofar as it is possible) the economic adversities which accompany blindness. In doing this the Congress would be recognizing that it is primarily these economic adversities, many of which are caused by mistaken social attitudes, that have held the blind back from leading fully productive lives. There are other examples, such as veterans' compensation, where the theory of providing individuals with an economic base from which to expand their opportunities has proven itself to be sound. This principle should now be put to the test in the Social Security Program.

The Advisory Council's report presents (but rejects) a proposal for an earnings offset provision to be placed in the law as a work incentive for all SSDI beneficiaries. The primary reason for rejecting this plan seems to be that persons with earnings of about $30,000 annually would continue to receive some portion of their disability insurance benefit. But the fact is that the number of blind people being paid over $30,000 annually in this country is very small. Most blind people do not even work.

Consider for a moment how the work incentives in Social Security are really out of focus with the work capacity of blind people. Half of the blind population is age 65 or older. Many have worked enough (especially as sighted people) to be qualified for Social Security retirement benefits. In that program by virtue of the earnings offset for retirees, these older blind people (who are mostly out of the workforce) have a greater work incentive than do the blind who are between the ages of 18 and 65. There are approximately 250,000 blind people who are age 65 or older in this country.

Once a blind person reaches age 69, the work incentive actually increases, because at that time the limitation on earnings is removed altogether. This means that the few blind people who can still work at that age can earn to their hearts' content even if they are earning over $30,000. Meanwhile, their blind counterparts age 64 and below are limited to earning no more than $700.00 per month. Many of these people could actually work more (subject to job availability) if they had the same work incentive as their blind counterparts at age 69 or older. But the fact is that these younger blind people are actually being paid to stay out of the workforce. That approach is wrong.

Rather than increasing the work incentive for these people (about 100,000 blind people who are SSDI beneficiaries), the Advisory Council actually recommends a work incentive decrease. The decrease would come by freezing future increases in the monthly SGA amount at $700.00 for current beneficiaries and establishing a lower ($500.00) per month SGA amount for new blind beneficiaries. SGA for this latter group would be increased annually as has been the case for all blind persons since 1978. Taking this course of action, with a lower SGA amount for blind persons eligible in the future, would only have a detrimental impact on work activity of the working-age blind. Blind people are not oblivious to the pure economics of the situation. Fewer will attempt work if this proposal is adopted. Moreover, if they do not attempt work, they will remain as beneficiaries of SSDI or SSI. The results can only be negative from a cost and humanitarian standpoint. Blind people and the American people as a whole will be better off if Congress now recognizes that limiting earnings of the working-age blind under SSDI is counter-productive and needlessly costly.

Mr. Chairman, we do agree with the Advisory Council's general recommendation that vocational rehabilitation services should be available to SSDI beneficiaries from sources other than the state vocational rehabilitation programs. Our specific recommendations for legislation in this area are contained in H.R. 4273, introduced in this session of Congress by Representative Harold Ford. Mr. Ford's bill would allow blind beneficiaries in either the SSDI or SSI programs the opportunity to select their own service-providing agencies (public or private). More to the point, beneficiaries under this bill would be free to design their own programs and pursue them with the assistance of the agencies of their choice.

This legislation responds to the experience of blind people in attempting to obtain suitable vocational rehabilitation services without being able to choose among agencies. Having no choice literally means that each blind individual is subject to the policies and philosophy of the public (state) agency that exists. If the counselors and supervisors in that program believe that a given blind person should not pursue a particular professional or vocational training course or job choice, it will not be permitted. Public funds will not be expended for that effort. When I suggest that there might be those who would arbitrarily limit the choice of blind job seekers, I am not engaging in speculation. Reports come every day that this is exactly what happens.

The blind person has no practical alternative but to cooperate with the agency's decision or appeal the decision and risk being branded as a troublemaker. Even if an appeal is made successfully, the blind person still lives with the reality that he or she is subject to constant pressure and manipulation, due to the agency's hold on the purse strings. These are the inescapable realities of an agency monopoly system for vocational rehabilitation, such as we have now.

Ironically, the law now requires beneficiaries to accept vocational rehabilitation services, but this is on the terms that they are offered by the particular state agency involved. Some agencies that we know, have actually required blind SSDI beneficiaries to pay for all (or the greater portion) of their vocational rehabilitation services. This occurs even when the only source of income is an SSDI check. It is no wonder that, under circumstances such as these, there is very little rehabilitation of SSDI beneficiaries taking place. Blind people receiving SSDI can ill afford to pay for their own vocational rehabilitation. That much is clear. If they are forced to pay for rehabilitation services, the objectives of the law and vocational rehabilitation will continue to be frustrated. That is why we want the opportunity to choose another agency.

Mr. Chairman, in concluding this testimony, I would like to restate and reemphasize the message that we have been giving to this subcommittee and the Congress for several years. The blind as a group are prepared to work and work hard. The legislation which we recommend to your attention constitutes an effort on our part to renounce our traditionally established lives of demeaning dependency and subordinate status. This legislation also expresses our firm determination to escape from many long decades of inactivity during which we have been constrained by society's ignorance, myths, and misconceptions. We seek to free ourselves from the captivity of ignorance, prejudice, and discrimination. We ask only the opportunity to lead normal, self-supporting, self-dependent lives. For our part, Mr. Chairman, we are committed to making the provisions of this legislation an effective instrument of rehabilitation, self-help, and self-support for the blind. All we ask is your support by your affirmation of these principles in guiding this legislation into public law.

Chairman JACOBS. Mr. Smurr.

STATEMENT OF R. DENNIS SMURR, ASSOCIATE ADVOCACY DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. SMURR. Thank you, Mr. Chairman.

I am Dennis Smurr. It is an honor and privilege for me to present to you the comments and concerns of our membership regarding the recently released report by the Disability Advisory Council concerning the Social Security Administration's mission of administering SSDI and SSI programs in light of a mixed and unclear Federal policy as to just what these two programs should have as a measure of effectiveness.

At the outset, PVA would like to commend each member of the Disability Advisory Council and the study team for the GAO for their time and effort to put together a comprehensive overview of not only the programs in question, but also the need for a better coordinated, well-articulated Federal policy on disability as it affects American citizens in particular and society in general.

Their findings and recommendations give us all food for serious thought as our Nation enters into its third century experimenting with a fragile concept of a democratic form of government of, by and for its own citizenry who are afforded certain inalienable rights in their pursuit of life, liberty and happiness.

Mr. Chairman, chronic disability continues to exist as an anomaly to the good life as perceived by many Americans, and it is for this reason it is proper for us to engage ourselves in today's hearings.

It is very important for us to remember that even though we are talking about a program that annually costs $20.4 billion, we are not talking about a program that allows its recipients to live a life of luxury.

The two studies completed by DAC and GAO clearly illustrate the shortcomings of the present system to adequately address the reemployment aspect of the SSA/VR program. The mere fact that one-half of 1 percent of program recipients return to successful employment speaks for itself that something is certainly wrong with the present system or at least the perception which program beneficiaries and the general public have of this important publicly administered, privately funded disability program.

I would like to make note of the fact that I am one of those who made a leap back into the work force through the SSDI-sponsored vocational rehabilitation program. In retrospect, I am not certain whether I sit here before you today as a direct result of my VR experience or in spite of it.

Because of my experience with VR, I would hate to estimate the number of young people who have just given up on life—not because they encountered a serious, chronic injury or illness, but because they could not survive the system that was designed to help them.

PVA has reviewed the legislative proposal entitled Social Security Work Incentive Act of 1988, and we support the overall intent of this legislation and hope this subcommittee can act on it.

We would like for this new proposal to contain a Medicare buy-in provision as outlined or proposed in Senate bill 936 and H.R. 1971, known as the Disabled American Work Incentive Act, introduced by Senator Durenberger and Congressman McMillan respectively.

Under the proposal, those disabled and working SSDI beneficiaries who exhaust their Medicare benefits under their extended period of eligibility would be able to buy continued Medicare coverage on a voluntary basis as unprotected elderly are allowed to do so at present, plus the disabled and working would be able to purchase the optional part B coverage.

This is more acceptable in that it does not involve any use of Medicaid moneys. I am certain the Social Security Work Incentive Act will undergo additional modification before it proves to be an acceptable option to be enacted into law.

PVA is eager to assist this subcommittee in making that a reality. Many PVA members are SSDI recipients, and they, like so many other persons with chronic disability, would appreciate the opportunity to attempt real world work experience with the assurance that if for some reason outside their control, their work effort was interrupted, then they and their family would be able to resume SSDI benefits.

In conclusion, PVA would again commend the DAC members for their report and their recommendations. We thank you, Mr. Chairman, for holding such a prompt hearing on this important matter, and we look forward to working with you and your subcommittee in making SSDI a more responsive and effective disability insurance program. That concludes my testimony. I will be happy to answer any questions.

Chairman Jacobs. Thank you.

[The statement of Mr. Smurr follows:]

STATEMENT OF R. DENNIS SMURR, ASSOCIATE ADVOCACY DIRECTOR, PARALYZED VETERANS OF AMERICA

Chairman Jacobs and Members of the Subcommittee, I am Dennis Smurr, Associate Advocacy Director for the Paralyzed Veterans of America. It is an honor and privilege for me to present to you the comments and concerns of our membership regarding the recently released report by the Disability Advisory Council concerning the Social Security Administration's mission of administering the Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) programs in light of a mixed and unclear Federal policy as to just what these two programs should have as a measure of effectiveness.

At the outset, PVA would like to commend each member of the Disability Advisory Council (DAC) for their time, dedication and effort to put together a very comprehensive overview of not only the programs in question, but also the need for a better coordinated, well articulated Federal policy on disability as it affects American citizens in particular and society in general. The DAC findings and its recommendations give us all food for serious thought as our nation enters into its third century experimenting with the fragile concept of a democratic form of government of, by, and for its own citizenry who are afforded certain inalienable rights in their pursuit of life, liberty and happiness.

Disability continues to exist as an anomaly to the good life as perceived by many Americans, and it is for this reason that it is proper for us to engage ourselves in today's hearings. It is also important that we remember the words of the great statesman Hubert H. Humphrey who said "The greatness of a nation should be judged not by how it serves its majority but by how it cares for its minorities." America's 36 million citizens with disabilities have unmet needs which must be addressed - hopefully today's hearing will be a step in that direction.

The Paralyzed Veterans of America (PVA) is a 41 year old veteran's service organization, chartered by Congress in 1971, to address the unique needs of this nation's catastrophically disabled veteran population. Our membership is not large, since to be a PVA member an individual must be a veteran and have incurred an injury or disease of the spinal cord which results in a varying degree of permanent paralysis. Because of this paralyzing condition, nearly all PVA members are mobility-impaired and must rely upon wheelchairs and other assistive devices for mobility. Many of our members must also rely upon family, friends, spouses, or other individuals to assist them in activities of daily living which they cannot perform for themselves because of their disability. This continuing need for personal assistance coupled with our knowledge of the cost of this care and devastating effects these costs can have on the disabled individual, his family and society in general, gives rise to our interest in the matter presently being discussed.

PVA's membership is comprised almost equally of service-connected and nonservice-connected disabled veterans. Our service-connected members are afforded monthly financial payments to compensate for their disability and reduced earning potential. Their compensation payments are not tied to their ability to work. They are also provided hospital and nursing home care, as needed, plus they are eligible to receive special housing grants to build, buy or modify their personal residence to better meet their physical needs.

Our nonservice-connected disabled members become eligible for a Veteran Administration (VA) pension benefit if their personal income falls below certain thresholds. They too are eligible for certain hospital and nursing home care, again if the need arises and certain qualifications are met. The present VA pension program which has been in effect since 1978 is very similar to Social Security in that it requires the veteran be unable to work and that he be totally and permanently disabled. The nonservice-connected pension is an income supplement, with the benefit amount directly linked to veteran's other forms of available income. Receipt of other benefits, such as SSI, SSDI, or workman's compensation may result in a reduction of the veteran's pension benefit. At the present time nearly 430,000 veterans receive benefits under this program and since the VA pension benefit for our nonservice-connected disabled are, in most cases, directly affected by the benefits received through SSDI, it is only fitting that PVA share with you its comments and concerns on the DAC findings and recommendations.

PVA has become a leading advocate for the needs of physically disabled persons regardless of whether they are a PVA member, a veteran, or simply an American with a physical impairment. We have attempted to break down many of the physical barriers that impede citizens with disabilities from regaining their rightful place in mainstream America. We work to dispel many of the myths which our society holds regarding the rights, abilities, and potentials of Americans who have encountered a life-altering physical disability either by accident or disease. PVA is extremely proud of all that we have been able to accomplish over the years.

We have been involved in dispelling myths and protecting basic civil rights because we are disabled Americans and part of a growing segment of our society who want to live our lives to the fullest, with all the privileges, dignities, and rights provided by our Constitution to other citizens of our nation. Our comments regarding the topic of this hearing stem from this concern for equality, self-direction, and quality of life.

The SSDI program presently serves about 2.8 million workers with disabilities and 1.3 million dependents. In 1987, the SSDI program expenditures amounted to $20.4 billion dollars, for an average annual benefit payment of $4,878.15 per program recipient.

The DAC report indicates the average SSDI family benefit for 1987 was $919.00 per month or $11,028 per year. Whereas, the General Accounting Office (GAO) study indicates that, as of September, 1986, the average household benefit was about $6,550 per year. Current Social Security Administration (SSA) regulations cap the maximum allowable family benefits at $1510 per month which translates into an annual family income of $18,120 per year. It is very important to remember that even though we are talking about a multi-billion dollar program we are not talking about a program that allows its recipients to live a life of luxury.

SSDI income is not subject to state or federal taxes nor is it adding any additional monies into the FICA fund which is, in itself, the source of the SSDI program money. Therefore, we are faced with an income replacement program that holds very little potential for any kind of monetary payback to society.

The question facing us today is two-fold. How can we afford to continue to make this ever increasing cash outlay each year, and how can we stabilize, contain, or reduce future SSDI program expenditures? Secondly, and more importantly, what changes should we make in the existing SSDI program that would allow, or in fact, encourage an individual worker who becomes disabled to return to some form of work activity which would enable him or her to once again become a tax paying member of our society?

The two studies just completed by the DAC and by the GAO clearly illustrate the shortcomings of the present system to adequately address the re-employment aspects of the SSDI program. The mere fact that less than ½ of 1 percent of all program recipients actually return to successful employment speaks for itself that something is certainly wrong with the present arrangement or at least the perception which program beneficiaries and the general public have of this very important publicly administered, privately funded disability insurance program.

I would like to make note of the fact, that I am one of that small minority who made the quantum leap back into the work force through the SSDI sponsored vocational rehabilitation (VR) program. In retrospect I am not certain whether I sit here before you today as a direct result of my VR experience or in spite of it. I say this because VR refused to assist me in my original work plan of becoming re-established in my pre-injury vocation as a salesman, even though all their own vocational evaluators, save for one psychologist, determined my work plan feasible and my market profit potentials excellent. The psychologist felt that I was not being realistic - a C-5 quadriplegic, paralyzed without use of hands or legs surely could not make a living selling medical supplies to hospitals. After more than 18 months of hassle, I challenged their decision, requested a meeting with the State VR Commissioner and stated that since they would not assist me in my original plan I wanted to return to college to pursue graduate studies. Two weeks later my vocational plan was approved and one month after that I began a new life as a college student.

I did not complete my graduate studies because I received a job offer from my present employer, the Paralyzed Veterans of America. That was in 1981, four years after I had broken my neck in a freak water skiing accident. I must say those first few years after my injury were extremely traumatic. I could not understand why I had to wait 5 months to receive SSDI benefits. My employer saw fit to terminate my employment three weeks after my accident. I was grateful he allowed me to continue on the company group health plan, if I paid the monthly premiums. My wife was overwhelmed with doctors bills and insurance forms. She contacted all the appropriate authorities - the SSA, the Veterans Administration, and the local welfare office. She notified all our creditors of our situation and we began our wait - a wait to see if and what we were eligible to receive.

I can truthfully say I would not have endured those early months were it not for the kindness and generosity of many friends, some of whom I knew personally but most only knew of me. The tax-supported agencies, which we all assume are there to help us in times of need, failed to respond in a timely and appropriate fashion. They made you feel inferior, as though you were imposing upon them or that you might be trying to get something for nothing. It is a demeaning experience and one that sets up an adversarial relationship which should not be allowed to develop because it undermines all the trust and faith which one may have in our public service entities.

My overall VR experience did nothing to restore my confidence that finally someone was truly interested in helping me put my shattered life back together. It was only after I personally challenged the system and demanded that my case be resolved, that VR began to take me seriously. I was 34 years old when I had my accident, I was more mature, had a better idea of what I wanted to do than the 18 to 25 year old male who is normally the victim of accidental injuries.

I would hate to estimate the number of young people who have just given up on life, not just because they encountered a serious, chronic injury or illness, but because they could not survive the system that is suppose to help. Both studies have clearly stated that the best indicator of future rehabilitation success is the motivational drive of the affected individual. I could not agree more, but I would also add that if the VR system, when working with severely disabled applicants, could be allowed to experiment, and possibly err, more in behalf of the applicant rather than be held so accountable to some theoretically proven, cost-benefit ratio, then more severely disabled young people would not be forced to live on the fringes of society in receipt of SSI or SSDI program payments.

I would also recommend serious consideration be given to implementing the comprehensive intervention model outlined in the DAC study as Appendix K. Early intervention coupled with a case management approach to the affected individual's unique circumstances could greatly reduce many of the counterproductive aspects of the present SSA/VR service delivery system.

Now I turn my discussion to the SSDI population who could possibly benefit from a new approach to SSA referral to VR services. Of the current 2.8 million SSDI program recipients, the GAO study estimates only 10-15 percent of this population are feasible candidates for VR services. That translates into a potential population of between 280,000 to 420,000 beneficiaries, who, if removed from the rolls and successfully returned to the work force, could save the SSDI trust fund between $3.1 to $4.6 billion in cash outlays (using the DAC estimated 1987 SSDI monthly benefit of $919.00 per family).

The present VR capacity would not permit all these beneficiaries to be rehabilitated in a single year, but it is feasible to anticipate that approximately 70,000 could be, which would mean that within a 4 to 6 year time frame, all existing potential beneficiaries could be returned to gainful employment.

Another consideration revealed in the DAC study is the fact that half of all SSDI worker beneficiaries are age 55 or older, and that these individuals view the SSDI program as a premature retirement program. Should VR monies be expended on this population group, or should the SGA level be raised for these older beneficiaries so that they might attempt some limited work activity without fear of benefit termination? PVA believes the latter idea has better merit than the first.

Also, PVA believes there is merit to giving consideration to dividing the SSDI population into two components - those age 50 and younger and those over the age of 50. For the older group the SSDI program would remain basically the same with the one exception of raising the current SGA to a level more representative of today's wages, for example $500 per month for 1988, with annual adjustments based upon changes in the Federal Benefit Rate. The younger category of SSDI beneficiaries would be eligible to become involved in a special status called "disabled and working".

If, upon an initial or continuing disability review, a SSDI recipient age 50 or under was determined to have re-employment potential, given the individual's age, education, disability, and marketability, then that individual would be required to be provided VR services. The new VR program would include not only vocational training, but also employment placement services, and post-employment follow-up. Such a proposal has already been tried by the Veterans Administration for its nonservice-connected disabled pension recipients and the results have been rather promising.

The "disabled and working" status for SSDI beneficiaries has already taken the form of a legislative proposal known as the "Social Security Work Incentives Act of 1988." This proposal is being offered in the U.S. Senate by Senators Reigle and Dole, and in the U.S. House of Representatives by Congressmen Bartlett and Matsui. PVA has reviewed this proposal and we support the overall intent of the legislation.

Under the new "Social Security Work Incentives Act", which parallels recently enacted changes made to the Section 1619 program of SSI, a SSDI beneficiary who returns to work is shifted into the new "disabled and working" status once his or her earnings exceeded the SGA (substantial gainful activity) level. Once in this status the beneficiary will have their monthly benefit reduced by one dollar for each two dollars of income earned, after an exclusion of the first $85.00. This sliding-scale arrangement of benefit reduction is in keeping with a DAC report study recommendation, it replicates the work incentives of the SSI program, and it better provides for a smooth transition into the work place without having to encounter a feast or famine income pattern.

The new proposal would also enable SSDI beneficiaries to retain their program eligibility, as long as their original disabling condition existed, even if their earnings increased to the point they were no longer receiving SSDI cash benefits. As with the SSI program arrangement, SSDI beneficiaries could go on and off the benefit program as their earnings might fluctuate due to changes in their health or employment. This "continued eligibility" provision is extremely important for a disabled person who wants to try employment opportunities in spite of their impairments. Without such as assurance few beneficiaries will risk work for fear they would be forced to re-establish themselves as disabled by SSA standards. We do have several reservations with the legislation as it presently exists.

PVA would prefer that this new proposal contain the Medicare "buy-in" provision as outlined and proposed in S.936/H.R.1971, known a the "Disabled Americans Work Incentive Act", introduced by Senator Dave Durenberger and Congressman Alex McMillian, respectively. Under the Durenberger-McMillian proposal, those "disabled and working" SSDI beneficiaries who exhaust their eligibility to Medicare benefits under their extended period of eligibility (EPE) would be able to buy continued Medicare coverage on a voluntary basis.

The premiums for Part A of Medicare (Hospital Insurance), would be set at the amount currently established for voluntary enrollment by the elderly. In addition, for those who would enroll in Part B of Medicare (Supplemental Medical Insurance), the premium would equal four times the premium that would be paid by enrollees covered under current law. Total premiums for any "disabled and working" individual could not exceed 8 percent of a monthly adjusted gross income standard established by the Secretary of HHS, but under no circumstances could the premiums levied be less than 25 percent of the levels established in the legislation.

A December 1986, CBO cost study of this "buy in" provision estimated, assuming the legislation would have been enacted so as to affect terminated DI beneficiaries in October 1987, that the first costs of this program would not arise until fiscal year 1990 at which time the maximum cost to the federal government would amount to $4 million and $11 million for the following year.

Of course, I'm certain the "Social Security Work Incentive Act" will undergo additional modification before it proves to be an acceptable option to be enacted into law. PVA is eager to assist this subcommittee and the bill sponosors in making this proposal a reality. Many PVA members are SSDI recipients, and they, like so many other persons with a chronic disability, would appreciate the opportunity to attempt real world, work experience with the assurance that, if for some reason outside their control, their work effort was interrupted then they and their family would be able to assume SSDI benefits.

In conclusion, PVA would again commend the DAC members for their report and their recommendations. We thank you Mr. Chairman for holding such a prompt hearing on this important matter and we look forward to working with you and your subcommittee in making the changes necessary which would bring SSDI into the 21st century and make it a more responsive and effective disability insurance program, given today's medical and technological advances. This concludes my testimony and I will be happy to answer any questions that I can. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Lessard.

STATEMENT OF WILLIAM J. LESSARD, JR., DIRECTOR OF POLICY AND RESEARCH, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. LESSARD. I am William Lessard, Jr., director of policy and research for the National Committee to Preserve Social Security and Medicare, a grassroots organization of 5 million members and supporters. We testified last June before the Disability Advisory Council, and I am pleased today to represent our disabled members and their families.

I will summarize my full statement, which has been submitted. The National Committee supports disability reforms designed to return the disabled to work. The Council's recommendations lay a foundation for a more effective vocational rehabilitation program for Social Security and SSI disability beneficiaries.

Even though the Council failed to recommend it, we urge the subcommittee, like many others did today, to give serious consideration to a disability benefit offset. The Council looked at options regarding work incentives, but in our judgment, only made minor recommendations.

Even if SSA improves its education efforts, many disabled individuals will still fear the abrupt loss of benefits. Simply by establishing an ability to work, a disabled beneficiary can lose his or her benefits. National Committee member, Verna Adler of New Brunswick, N.J., wrote to us about her 46-year-old brain-damaged son who receives disability.

> As it stands now, if he works, he loses his disability, yet there are things he can do like dishwashing. But if he takes such a low-paying job, he will lose his Social Security benefits. He would need both the benefits and the poverty-level income to make it on his own. Is there any possibility the rules will be changed?

Unfortunately, the Council did not recognize this fear of losing benefits as the major disincentive for the disabled not working. As a result, the Council did not recommend an offset for the Social Security program, as Mrs. Adler had hoped. She will be pleased, however, with Congressman Bartlett's initiative.

The Council objected that a disabled beneficiary could have substantial earned and unearned income and still receive some cash benefits and Medicare. On the one hand, the income of disabled beneficiaries should be irrelevant in the design of the disability insurance program.

On the other hand, the high-income examples given in the Council's report are rather unrepresentative of the disabled population. The Council also objected that a disability offset would induce more disabled workers to apply for benefits.

Assuming that these individuals qualify for benefits, the National Committee fails to see any reason for denying disability benefits to disabled insured workers.

We agree with the Council that many people with disabilities, if provided with timely and appropriate services, can work and that they should be encouraged to do so.

Disabled individuals do have the same right and obligation to work as nondisabled individuals. And they also have a moral and social claim on services necessary to restore their ability to contribute to the Nation's and their own economic well-being.

Adequate resources and an effective employment policy will be needed to make rehabilitation work.

While supportive of rehabilitation, the National Committee would like to caution Congress not to have unrealistic expectations about returning large numbers of disabled individuals to the work force and saving money.

An undue emphasis on these goals could undermine the primary goal, which is to provide income and medical protection to the disabled. The General Accounting Office recently concluded only 10 to 15 percent of Social Security beneficiaries are likely candidates for rehabilitation.

In addition to this basic limitation on the number of rehabilitation candidates, the maximum potential will never be reached until the disability program stops sending mixed signals. Beneficiaries now have an all-or-nothing choice. Only the most motivated will risk all, which is why we have recommended a disability offset.

In addition to discussing administrative inconsistencies, the National Committee wishes the Council had looked at legislative inconsistencies, both of which raise serious questions about the basic fairness of the Social Security disability program.

The National Committee hopes that the subcommittee will not neglect deeply important and needed reforms to correct other problems in the disability program, in addition to considering the Council's recommendation and Congressman Bartlett's legislation to encourage the disabled to work.

Thank you.

Chairman JACOBS. Thank you, Mr. Lessard. I thank the panel for their contribution to the subcommittee.

[The statement of Mr. Lessard follows:]

STATEMENT OF WILLIAM J. LESSARD, JR., NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am William J. Lessard, Jr., Director of Policy and Research for the National Committee to Preserve Social Security and Medicare, a grassroots organization of five million members and supporters. On behalf of our members, I testified last June before the Disability Advisory Council and I am pleased to be here today to represent our disabled members and their families.

The National Committee supports disability reforms designed to encourage the disabled to work, and in that spirit endorses most of the Disability Advisory Council's recommendations for demonstration projects, better statistics and changes in the program. The Council's recommendations lay a foundation for a more effective vocational rehabilitation program for Social Security and SSI disability beneficiaries, if given adequate resources. Even though the Council failed to recommend it, we urge the Subcommittee to give serious consideration to a disability offset which is needed to lessen the fear of losing benefits. This fear is the single most important disincentive to return to work for disabled beneficiaries.

The National Committee would like to caution Congress not to have unrealistic expectations about the potential of vocational rehabilitation to return large numbers of disabled individuals to productive work and thus save the government money. An undue emphasis on returning the disabled to the workforce could undermine the primary goal of the disability program which is to provide income and medical protection to the disabled.

The National Committee is also disappointed with the narrow scope of the Council's recommendations. The Council's legislative charge was narrowly focused on returning beneficiaries to the workforce and the Commissioner added a requirement that recommendations be cost-neutral.

The Council looked at issues regarding work incentives and disincentives, but only made minor recommendations similar to those made by the National Committee to modify the trial work period and raise the level of substantial gainful activity. Even if SSA improves its education efforts, many disabled individuals will still fear the abrupt loss of benefits because, by establishing an ability to engage in substantial gainful activity, a disabled beneficiary can lose his or her trial work months. National Committee member Verna Adler of New Brunswick, New Jersey, wrote to us about her 46-year-old brain damaged son who receives disability:

> "As it stands now, if he works he loses his disability. Yet there are things he can do like dish washing. If he takes such a low paying job he will lose his Social Security benefits. He would need both the benefits and the poverty level income to make it on his own. Is there any possibility the rules will be changed?"

We were disappointed that the Council did not recognize fear of losing benefits as the major disincentive for the disabled not working, despite the overwhelming opinion of vocational rehabilitation counselors that this is very important. As a result, the Council did not recommend a benefit offset for the Social Security disability program similar to section 1619 of the SSI program as we had hoped. A benefit offset would reduce benefits gradually as earnings increased, and wouldallow the beneficiary to maintain Medicare eligibility as long as there was no medical improvement in the disabling condition. Health insurance coverage is not just a concern of the beneficiary, it is also a concern of the potential employer, especially if the potential employer operates a small business and is very sensitive to his costs for health insurance.

Had the Disability Advisory Council not been constrained by instructions from the Commissioner to keep its recommendations cost-neutral, the Disability Advisory Council might have recommended a benefit offset or a Medicare purchase or subsidy option. Current provisions in law that provide for continued eligibility for Medicare up to 48 months (but only as secondary payer) are a step in the right direction.

But the arguments that the Council advanced against the disability offset are very disturbing. The Council objected to the fact that a disabled beneficiary could have substantial earned and unearned income and still receive some cash benefits and Medicare. On the one hand, the income of disabled beneficiaries should be irrelevant in the design of the disability insurance program. On the other hand, the income examples given in the Council's report are unrepresentative of the disabled population. GAO found that disability beneficiaries had income and asset levels well below those of the general population or retired beneficiaries. In fact 17 percent of married disability beneficiaries and 55 percent of unmarried beneficiaries had family income below the poverty level, requiring public assistance and in-kind benefits under other programs to meet basic needs.

The Council's objection that a disability offset would create different standards for applicants and current beneficiaries is a tacit admission of the difficulty in eliminating work disincentives unless the current disability program is changed. The Council also objected that a disability offset would induce more disabled workers to apply for benefits. Assuming that these individuals qualify for benefits, the National Committee fails to see any reason for denying disabled insured workers the benefits of a disability offset.

Conversely, we object to the listing of benefit reductions as an incentive to work (p. 65). When Congress reduced disability benefits in 1980, it intended to encourage beneficiaries to come off the rolls or to discourage severely disabled workers from applying for benefits. The Council noted, however, that the proportion of disabled beneficiaries who leave the rolls each year as a result of work activity "has not changed appreciably in the last ten years." (p. 67) The primary consequence of the 1980 amendments was to make disabled workers and their families poorer.

We agree with the Council that many people with disabilities, if provided with timely and appropriate services, can work and that they should be encouraged to do so. Though the primary emphasis of our testimony is a proper framework of incentives for disabled individuals to return to work, combined with protection of adequate and equitable disability benefits, the National Committee firmly endorses the Disability Advisory Council's commitment to vocational rehabilitation. Disabled individuals not only have the same "right and obligation to work" as non-disabled individuals, they have a moral and social claim on a full range of services necessary to restore their ability to contribute their talents and energies to the nation's and their own economic well being.

The Council rightly deplores the reduction in the percentage of Social Security beneficiaries rehabilitated in recent years, but unless there is a major new commitment of resources to vocational rehabilitation, assigning priority to SSDI and SSI claimants will only deprive other clients of vocational rehabilitation services that they, too, require. Comprehensive case management accompanied by a full range of medical, social, and educational services demands a greater commitment of resources than the Council recommended.

It is important to integrate vocational rehabilitation with an effective employment policy. It would be the cruelest kind of injustice to retrain disabled individuals so that they lost their eligibility for disability benefits, but refrain from providing the resources needed to ensure they are successfully placed in jobs which take advantage of their skills. Vocational rehabilitation services must also work with employers to place rehabilitated workers into appropriate jobs either with their former employers or with new employers. Equally important, the full force of the law should be brought against employers who violate anti-discrimination and economic opportunity laws as the Council recommended.

In terms of evaluating the potential of rehabilitation for Social Security and SSI disabled beneficiaries, however, we want to point out that the General Accounting Office (GAO) recently concluded that "probably 85 to 90 percent are either too old to be considered realistic candidates for vocational rehabilitation or are unlikely candidates because of the nature or severity of their disability." (HRD-88-11 *Little Success Achieved in Rehabilitating Disabled Beneficiaries*, p. 21) The problem apparently is not the referral rate which is 11.1 percent, but the adequacy of the efforts made with those referred.

A typical disability beneficiary, according to the GAO, is a blue collar male worker over age 55 with high school education or less who had few financial assets, limited income and multiple physical problems which were unlikely to improve. (HRD-88-35BR *Demographic and Economic Characteristics of New Beneficiaries*, pp. 26-27) This portrait contrasts sharply with the Health Insurance Association of America's outline of characteristics likely to be predictors of a successful rehabilitation candidate. Motivation was the most important predictor, but next in importance were an urban geographical location, age 45 or under, high school education, non-progressive health condition, and transferrable skills or potential for retraining. (Report of the DAC, Appendix L, p. 3) The typical beneficiary's characteristics also contrast with the vocational rehabilitation selection criteria established by the Social Security Administration and the Rehabilitation Services Administration.

In addition to this basic limitation on the number of beneficiaries who could benefit from vocational rehabilitation, the maximum potential of vocational rehabilitation will never be reached until the disability program resolves the inherent confusion in the design of the disability program. As the Council put it, "Beneficiaries are thus sent mixed signals--they must prove that their impairments prevent them from working for at least 12 months in order to be awarded benefits; then they are encouraged to return to work and forfeit their benefits." (Report of the DAC, p. 21) This confusion results in a disincentive to many beneficiaries returning to work because they fear losing benefits. As discussed earlier, the major deficiency in the council's report is its failure to make adequate recommendations to eliminate this disincentive.

The National Committee shares the Advisory Council's concern that the lack of consistency in disability determinations raises "serious questions about the basic operational integrity and fairness of SSA's disability program." (p. 83) The National Committee supports the recommendation for more precise standards and criteria for determining eligibility and the recommendation that the standards go through the Federal rule making process. But efforts to achieve uniformity must not initiate another assault on the disabled such as occurred from 1981 through 1983 with Continuing Disability Reviews conducted by state Disability Determination Services, followed by successive layers of "quality assurance," each of which denied more claimants.

The National Committee dissents strongly from the recommendation to study the Medical Improvement Review Standard used in Continuing Disability Reviews. Congress established this standard in 1984 in response to administrative abuses and purposely put the burden of proof on the Administration that the disabled beneficiary had recovered. We see no productive purpose in reopening this issue.

In addition to discussing administrative inconsistencies, the National Committee wishes that the Council had looked at statutory inconsistencies which also raise serious qusetions about the basic fairness of SSA's disability program. The Council's report gives the impression that there is lack of uniformity only in the application of the statutory definition of disability, but that the definition itself is uniform. (p. 82) But that is not true. The definition of disability is even stricter for disabled widows and widowers applying for Social Security benefits than it is for other Social Security or SSI disability claimants. Disabled widows and widowers are the only group of disabled beneficiaries who also have a minimum age requirement (age 50), suffer actuarial reductions if they are less than 65 years of age, and can lose eligibility for benefits prior to age 60 if the disability doesn't begin within seven years of a spouse's death. A National Committee member from North Platte, Nebraska, was discouraged by the discriminatory rules from applying for disabled widow benefits because she was cautioned she could lose her disabled worker benefits for which she had qualified before her husband died and before she turned 50. According to her letter to the National Committee:

> "I checked with Social Security and they told me I had to apply for my widow's disability and would have to go through everything again. They said it was harder to get and I may lose my benefits I have now. The way they talked, I felt maybe it was better if I just let it go and apply for my widow's Social Security at age 60."

The denial of early retirement benefits to disabled spouses of annuitants is also inconsistent with the philosophy of the Disability Insurance program that disability entitles an individual to be treated as if he or she had reached full retirement age. Likewise, spouses of severely disabled beneficiaries are not eligible for benefits until they reach retirement age, even if they are unable to work because their spouse needs constant care. According to GAO, 13 percent of beneficiaries are bedridden and ten percent are wheelchair bound.

These restrictions and others, like the disability cap for public employees, not only cause significant hardships, as illustrated by letters from our members, but are perceived as an unfair denial of Social Security protection for which workers have paid. The National Committee hopes that the Subcommittee will not neglect equally important and needed reforms to correct these problems in the disability program in addition to considering the Council's recommendations to encourage the disabled to work.

Thank you.

Chairman Jacobs. Our final panel today consists of the National Head Injury Foundation, Mr. Bartolomeo Larichiuta; the National Alliance for the Mentally Ill, Jim Havel; and the Association for Retarded Citizens in the United States, Elizabeth Boggs.

STATEMENT OF BARTOLOMEO LARICHIUTA, NATIONAL HEAD INJURY FOUNDATION

Mr. Larichiuta. My name is Bartolomeo Larichiuta. I had a bad motorcyle accident in spring 1985, and injured my head. I was in a coma for 2 weeks and was hospitalized for 2½ months.

I look like I am OK now, and that is a problem, because I am not. The accident caused brain damage, and I still have trouble remembering a lot of things. Sometimes when I am stressed, my brain scrambles; I can't focus on the immediate issue. I was making good money before the accident selling securities, but I couldn't do that now.

My mother applied for Social Security disability payments while I was still hospitalized, and that is what I am living on now. It is a good thing she applied soon while I was still hospitalized and not walking and talking like I am now, because if I had applied later looking like I do now, people who work there probably wouldn't have given me the disability payment at all.

I have heard about the head-injured people who didn't apply early enough for SSDI and they looked too good to persuade the Social Security people they needed the money. I know of one person who dresses nice and is always polite when he went in there, and kept getting refused, but he talked too much on the job, dumped stuff and nobody wanted to hear him or wanted to be near him, and he couldn't remember anything about what he was supposed to be doing.

When he couldn't remember, he would start wandering around and talking silly to everyone. Then he would get fired again. Finally, his mother talked to her Congressman and they got SSDI payments for him.

People with head injuries heal up pretty good on the outside sometimes, but there is injury to the brain that is invisible. Brain damage is slow to heal, and it is better to have two broken legs than brain damage. Legs heal faster than that.

You can take years to heal brain damage. There is no guarantee you will ever heal completely. When head-injured people are hurt so bad they can't work, can't talk plain, they get SSDI payments, because they can see they are really crippled.

What about the crippling you can't see? Bad memory, emotional problems, not being able to figure out to do things can prevent a person from being able to work, too, and be effective. There is a head-injured women who wrote a book about her bad experience the first years of her brain damage.

She said that the things she hated most to hear from people is, "Say, you look great, when are you going to get a job?" She just couldn't do the work anymore, not until years and years later. Head-injured people need more consideration than they are getting from SSDI.

I am afraid to go to Social Security offices, because they might take one look at me and stop my disability benefits, but that wouldn't help me remembering things better. I am trying to get into real estate sales now, and so far I have taken a real estate class at a community college three times so far since my accident, trying to get information to sink in so I can use it.

People need to realize brain damage can be an invisible disability. Something subtle that shows up on the job might not show up in the office interview. I get the feeling they think that they can tell whether you are doing good or bad just by looking at you. I have been there and felt that.

The big issue—a big issue for me in SSDI payments is I don't dare get a full-time job I can do—at my cousin's takeout ribs place where I am working part time now, I can't earn as much full time as I get from working at all, from not working at all. I can't afford to go without the health insurance I get from SSDI.

I think there ought to be some way to encourage people getting back to work so they don't get penalized for working. I don't like sitting around the apartment most of the time, it is boring. I just can't afford right now to take a chance of working and losing all my benefits.

So, in summary, I think there could be two improvements to SSDI that would help people disabled from traumatic head injuries: One, for Social Security personnel to accept that people with head injuries may be very disabled in their thinking or memory or emotions even though they might look pretty good from the outside. And two, for there to be a system to let people get back to work gradually without losing their Social Security health insurance and most of their benefits.

The way it is now, you can't afford to work.

Chairman JACOBS. Mr. Havel.

STATEMENT OF JIM HAVEL, DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL ALLIANCE FOR THE MENTALLY ILL

Mr. HAVEL. I have a written statement I believe has been distributed. Earlier this morning, at the commencement of the hearings, you made some comments citing the value of redundancies in recall, and as the morning has progressed and I have listened to successive witnesses, I believe——

Chairman JACOBS. You are well educated by now?

Mr. HAVEL. It must be impressed on the memory. That message has been consistent all morning. It is that essentially persons with disabilities want to work and many who are on SSDI will make the effort if barriers are eliminated.

The National Alliance for the Mentally Ill, which represents 65,000 families with mental illnesses, subscribes to that view, and believes we must open up opportunities for individuals to reenter the work force. But we feel the Advisory Council's recommendations fall short of the mark.

We have reviewed the Social Security Work Incentive Act of 1988 that was introduced by Congressmen Bartlett, Levin, Gradison, and Matsui, and we believe that it is an alternative that would make a significant contribution to removing some of the work disincentives that have kept otherwise capable people from entering the labor force.

The bill presents a realistic alternative to the substantial gainful activities test, and would permit people to work without fear of being dropped from the rolls. The continuation of SSDI disability is particularly important for the people we advocate.

Mental illness is so often unpredictable. Successful work experience may be sporadic and interrupted by recurrence of symptoms. For some, sustained employment is possible. Even where it is not, intermittent work is therapeutically and socially preferable to continued idleness.

Because of the stigma which attaches to mental illness and the prevalence of discriminatory insurance coverage for brain diseases, the Medicare buy-in is an essential feature of the Bartlett proposal.

Too often for a person with mental illness who takes a job, that person finds that he or she is unable to obtain insurance through their employer, because they are either working part time or at an entry level position that does not offer insurance benefits.

When they seek individual coverage, newly working persons with mental illnesses are frequently turned down because of the preexisting conditions or are confronted with exclusions and seriously limited benefits. Premiums may be exorbitant and thus, rather than building security, a job for such persons may dramatically elevate fears and insecurities. The buy-in feature of the Bartlett bill, in our judgment, offers an equitable and attractive incentive to work and addresses this problem forthrightly.

We have seen how similar provisions under SSI have had a positive impact on the employment of Americans with disabilities. Under section 1619(a), the number of SSI recipients receiving payments, despite working at the substantial gainful activity level, goes from 1,436 in June of 1987 to 14,500 by the end last year.

Under 1619(b), persons continuing Medicaid coverage also increased significantly. So, from this model, we know that work incentives can be effective in promoting reentry into the work force by many persons currently outside the employment market.

People with mental illnesses, like people with other disabilities, can make significant contributions to our society. They are currently a wasted resource of talent and ability. Our Nation needs to expand opportunities for gainful employment and to remove motivational barriers to participation for those who are ready for this important step toward fulfillment.

A job is more than a paycheck. It provides an identity and a purpose. It offers challenge and reward. It is the corner element in the concept of basic human dignity. To the extent we can help people with mental illnesses and other disabilities at all levels of functioning to regain a sense of hope, a sense that there may be a future better than the darkness now surrounding their disability, to that extent, we can enrich both their lives and our own.

Our Nation's greatest treasure is our people. We cannot afford to squander that treasure through neglect. Persons with mental illnesses and other disabilities deserve the same opportunities as all other Americans to achieve their full potential and make their mark on the society of which they are a part.

[The statement of Mr. Havel follows:]

STATEMENT OF JIM HAVEL, DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL ALLIANCE FOR THE MENTALLY ILL (1901 NORTH FORT MYER DRIVE, SUITE 500, ARLINGTON, VIRGINIA 22209), BEFORE THE WAYS AND MEANS SUBCOMMITTEE ON SOCIAL SECURITY, MAY 26, 1988:

Mr. Chairman, Members of the Subcommittee:

On behalf of the National Alliance for the Mentally Ill (NAMI) and its more than 800 affiliates nationwide, I would like to thank you for this opportunity to present our views on Social Security work incentives as they relate to persons with mental illnesses.

Our Alliance is a national network of self-support groups composed of families of persons with serious mental illnesses like schizophrenia, major depression, and bipolar disorders. As a family organization, we include mental health consumers among our membership and are proud of the contributions of our Client Council, which advises the NAMI Board of Directors on major policy issues. I regret that time considerations prevented us from having a consumer speak directly to you about these issues, since I know first hand experience is a more powerful persuader than anything I could offer. But I am happy to nonetheless be able to share with you some of the insights which have arisen from our collective family experience.

First, I would like to emphasize that serious mental illnesses differ significantly from other disabilities in the nature of the impediments they present for prospective employment. People who are mentally ill are not mentally retarded (although some persons may be diagnosed with both disabilities). In fact, many are college graduates or persons with advanced degrees in their chosen fields. Typically, a person with schizophrenia first manifests their illness during young adulthood. This and other mental illnesses are no-fault brain diseases which science has recently identified as having a genetic component. Our understanding of mental illnesses is still relatively primitive and the exact etiologies are unknown, but we do know that mental illness is not a chosen lifestyle, not the result of a poor home environment, and not the result of character flaws in an individual. And we know that mental illnesses at the present time cannot be prevented or cured, although their symptoms can be controlled through medications and other external supports.

Our families, however, are constantly dismayed by the ignorance and stigma which surrounds mental illnesses. We find official statistics lumping persons with mental illnesses and those with mental retardation into a single unit of data labeled "mental impairments." We are in daily contact with programs which fail to differentiate between the needs of persons with mental illness and those with other disabilities.

There are, to be sure, similarities across the various populations with disabilities. All are, to a lesser or greater extent, capable of productive labor, of making more of a contribution to our society than opportunities currently afford. All suffer from some discrimination. All must fight against a paternalistic view of their abilities in the struggle for independence. All know the debilitating weight of poverty and subsistence survival as a common denominator.

But having recognized these cross-disability characteristics, there remain unique differences in the needs of the various populations with disabilities served by the Social Security Administration programs. Particularly with regard to persons with mental illnesses who comprise the group of special interest to NAMI, the application of general eligibility criteria, uniform services, and common outcome expectations for all disabilities has sometimes been inappropriate.

SSDI clients with serious mental illnesses, for example, require special kinds of supports because the nature of their disabilities are often substantively different from other SSDI clients. Persons with mental illnesses may fluctuate from day to day in their functional level. Mental illnesses are cyclical illnesses. And, for most persons, mental illness will remain with them throughout their lives. But under closely monitored medical supervision, many clients could re-enter the work force and engage in productive labor, even if it is not on a full-time basis. Some, unfortunately, are incapable of any level of employment, but could benefit from low-stress activities that are pre-vocational in nature.

One of the things that prevent more highly functional SSDI clients with mental illnesses from rejoining the work force in any capacity is the design of the SSDI benefit package. Under the current regulations, an SSDI client risks the loss of vital services if he or she becomes employed. The "substantial gainful activity" test acts as a disincentive, as does the potential loss of Medicare coverage after the trial work period and extended period of eligibility.

Perhaps that helps explain why only 1/2 of 1% of all SSDI beneficiaries successfully make the transition back into the work force. But we do not think the recommendations of the Disability Advisory Council go far enough toward correcting this dismal record. More demonstration projects will only confirm what we already know: That people with disabilities want to work and many now on SSDI will make the effort if existing barriers are eliminated.

We have reviewed the Social Security Work Incentives Act of 1988, introduced by Messrs. Bartlett, Gradison, Levin, and Matsui, and think it would make a significant contribution to removing some of the work disincentives which have kept otherwise capable persons with mental illnesses from re-entering the labor force. The bill presents a realistic alternative to the "substantial gainful activity" test and would permit people to "try their wings" without fear of being prematurely dropped from the rolls. The continuation of SSDI eligibility is particularly important to the people for whom we advocate, because mental illness is so often recidivistic and unpredictable. Successful work experience may be sporadic and interrupted by the recurrence of symptoms. But, for some, sustained employment is possible and even where it is not, intermittent work is therapeutically and socially preferable to continued idleness.

Because of the stigma which attaches to mental illness and the prevalence of discriminatory insurance coverage for brain diseases, the Medicare "buy-in" is an essential feature of the proposal for our loved ones. Too often, the person with a mental illness who takes a job finds that he or she is unable to obtain insurance through their employer because they are either working part-time or in an entry-level position that does not offer an insurance benefit. When they seek individual coverage, newly working persons with mental illnesses are frequently turned down because of their pre-existing conditions or are confronted with exclusions and seriously limited benefits. Premiums may be exorbitant. And thus, rather than building security, a job for such persons may dramatically elevate fears and insecurities. The "buy-in" feature of the Bartlett bill offers an equitable and attractive incentive to work.

We have seen how similar provisions under SSI have had a positive impact on the employment of Americans with disabilities. Under section 1619 (a), the number of SSI recipients receiving payments despite working at the "substantial gainful activity" level rose from 1,436 in June, 1987 to 14,559 by the end of last year. Under 1619 (b), persons continuing Medicaid coverage after discontinuance of SSI payments increased from 12,470 to 15,632 during the same period. From this model, we know that work incentives can be effective in promoting re-entry into the work force by many persons currently outside the employment market.

People with mental illnesses, like people with other disabilities, can make significant contributions to our society. They are currently a wasted resource of talent and ability. Our nation needs to expand opportunities for gainful employment and to remove motivational barriers to participation for those who are ready for this important step toward fulfillment.

A job is more than a paycheck. It provides identity and purpose. It offers challenge and reward. And it is a core element in the concept of basic human dignity.

To the extent that we can help people with mental illnesses--at all levels of functioning--regain a sense of hope, a sense that there may be a future of brighter hue than the darkness now surrounding their illness--to that extent we can enrich both their lives and our own. Our nation's greatest treasure is its people. We cannot afford to squander that treasure through neglect. Persons with mental illnesses deserve the same opportunities as all other Americans to achieve their full potential and make their mark upon the society of which they are a part.

The Social Security Work Incentives Act of 1988 is an important piece of legislation for our constituency and we urge you to give it your support. NAMI considers this measure a more effective response to the problems people face under SSDI than the demonstration projects urged by the Disability Advisory Council and hope it will receive your favorable consideration.

Thank you.

Chairman JACOBS. Ms. Boggs.

STATEMENT OF ELIZABETH M. BOGGS, PH.D., MEMBER, GOVERNMENTAL AFFAIRS COMMITTEE, ASSOCIATION FOR RETARDED CITIZENS OF THE UNITED STATES

Ms. BOGGS. I am Elizabeth Boggs. This panel appears to be dealing with disabilities that occur inside the head. I think it would be useful if I explained my personal connection. Some of the people who testified have disabilities that are obvious. Paradoxically, blindness is a very visible disability.

I am the parent of a son who is 42 years old and has been disabled since infancy. He is profoundly retarded. He has seizures. He does not understand the spoken word. He has no concept of what work is. He is one of the people for whom it can be said there is no doubt that he is within the definition of the Social Security Act and in fact, he receives adult disabled child's benefits on the record of his deceased father.

I receive Social Security benefits on a combination of my own earnings record and my husband's earnings record. I am 75 years old. I have been active in promoting the Association for Retarded Citizens since its founding in 1950. I am, notwithstanding my personal connection, very much concerned with the impact of Social Security and SSI policy on people who are less severely retarded than my son. We have a statement here which has been submitted for the record, and which reinforces in many ways the statements that have been made by other people. I won't repeat that. I do want to point out that people with mental retardation constitute a significant portion of the clientele in SSI and to a significant extent, under Social Security. We have about 24 percent of the SSI disabled recipients who are of working age. People with mental retardation constitute more than half of the total number of people who receive Social Security as adults disabled in childhood. They meet the same disability definition as disabled workers, but their benefits are counted under the auxiliaries program, so they may be costed under retirement, survivors, or disability, as the case may be. There are about 550,000 people on those ADC rolls. A little over 60 percent of them who are mentally retarded.

We are very pleased with the provisions of 1619(a). There again, 37 percent of the people who have taken advantage of the basic 1619(a) provisions are mentally retarded. They are younger people. People who are getting SSI by and large are the younger people who have never been in the work force and never been able to establish a basis for Social Security on their own record.

We were disappointed that the Council did not grapple fully with the issue of extending the section 1619 concept to the disabled population that receives Social Security benefits either as disabled workers, SSDI, or under the adult disabled child program, or for that matter the disabled widows program.

We do feel that the Council did not have the full benefit of knowing about the results we are now getting under 1619 (a) and (b), and we point out that we were delayed in getting those advantages by the initial demonstration approach to that issue. The legislation enacted in 1981 was limited to a 3-year demonstration. This meant that nobody could be given assurance that, if he entered the program under those circumstances, his Medicaid would be intact 3 years hence. That was a strong deterrent, so that that was not a demonstration of how this program could work.

Once we got a genuine program in place, we were able to sell it to people. By that, I mean we were able to assure people that the benefits would be there. We have seen a dramatic increase in the use of section 1619 (a) and (b).

In the second place we do feel that the down-playing of the incentives based on some of the survey material is flawed. I mean that the surveys were flawed, because what the interviewers were doing basically was asking to people, "Can you work? Would you work if it didn't destroy your benefits?"

If the disabled person is giving the answer to a stranger, and the answer we are looking for is "Yes, I could work if I wanted to," the respondent has to deny his disability and I don't think that that is a fair test of the true incentives for a person to attempt work despite a disability.

When people with disabilities talk to Congressman Bartlett, they know he is not going to make a misinterpretation of their desire to try to work.

I want to speak particularly of a population that has not been mentioned here. Those are the dual beneficiaries, people who get both SSI and Social Security benefits, for whatever reason. Well, they get SSI because their Social Security benefits are low.

The effect of having some unearned income is to cut what is called the breakeven point—the point at which your earnings cause you to lose your SSI—way down, much lower than it is if you have no unearned income. Social Security benefits are considered unearned income.

If you review the statistics, you find that about 20 percent of the people who are using 1619(b), the Medicaid continuation, are earning less than $300 a month. They are not even touched by the SGA. But they are cut off by the breakeven point approach. There are others, another 30 percent or so, who are earning between $300 and the normal breakeven point. I can only assume that either they have other unearned income or, more likely, that their Social Security benefits are continuing during their trial work period; if so the Social Security benefits are going to stop in a short time. If that is the case, then their SSI benefits will increase to make up the difference. In other words, it transfers what has been a Social Security trust fund cost to the general funds. That is scarcely what anybody is intending.

I believe, therefore, that we should look carefully at these dual beneficiaries, because they are clearly not the high-incomers that are being used as an argument for not dealing with the Social Security SSDI disincentive issue.

I think the high-incomers have other characteristics if you look at them. People with high Social Security benefits were once high earners. If you look at $300 a month or $700 a month, a change in SGA is not going to motivate somebody one way or the other if he is used to earning $50,000 and his Social Security benefits are based on his having had that kind of income in the past.

So, the diversity of incentives in various personal situations needs to be further examined. I hope we will not wait until we solve all of the different problems associated with SSDI before doing something more about solving the problems of dual beneficiaries and others that get modest Social Security benefits and who would respond to the right incentives.

[The statement of Ms. Boggs follows:]

STATEMENT OF ELIZABETH M. BOGGS, PH.D., ASSOCIATION FOR RETARDED CITIZENS OF THE UNITED STATES

On behalf of the Association for Retarded Citizens of the United States, I want to thank you for the opportunity to testify before the Subcommittee on Social Security regarding the Social Security Disability Advisory Council's report and the General Accounting Office report, "Little Success Achieved in Rehabilitating Disabled Beneficiaries."

The ARC, marking its 38th year of nationwide service to people with mental retardation, is made up of over 160,000 members in some 1,300 local and state ARC chapters located across the country. Together the ARCs form the largest voluntary organization in the United States devoted solely to the welfare of people who are mentally retarded and their families.

In the United States, there are approximately two million children and adults identified as having mental retardation. Included in this group are individuals with moderate, severe or profound retardation and some persons considered to be between the mild and moderate range of mental retardation. As many as three to four million more persons may be identified at some point in their lives as having mild mental retardation.

People with mental retardation receive benefits from both the Title XVI and Title II disability programs of Social Security. Approximately 24 percent of persons with disabilities receiving Supplemental Security Income (SSI) (or approximately 386,000 people) are eligible on the basis of mental retardation. Approximately 12 percent of Social Security Disability Insurance (SSDI) disabled workers (or approximately 56,000 persons) under the age of 40 are eligible on the basis of mental retardation. In December, 1986, it is estimated that approximately 340,000 people were receiving SSDI payments as adults disabled during childhood on the basis of mental retardation.

Dramatic changes have taken place over the last two decades in the philosophies underlying the provision of services to people who are mentally retarded: systems have evolved from medical care models with few expectations for improvements in the individual's level of personal or economic development to the current recognition of the capacity of all persons with severe disabilities to learn, grow, develop, and become more personally and economically productive and independent. It is not at all unusual to find individuals who were once thought totally dependent and unable to work, now at work in sheltered, supported, or competitive work environments and contributing to the economy and to the tax base. Others who might want to work in these settings don't because of fear of the loss of necessary supports. It must be remembered that many such individuals are able to be integrated into the workforce and into society only with continued support. Their personal accomplishments in working despite severe disabilities are often very dependent upon underlying supports available to them such as job coaches and other work related supports, transportation, medical services, supplemental income, housing assistance, and continued training, supervision, or skills development.

Recognizing the importance of the Social Security disability programs in the lives of persons with mental retardation, the ARC followed with great interest the work and deliberations of the Social Security Disability Advisory Council. ARC submitted testimony to the Council and ARC staff attended most of the Council's meetings. While our concerns were many, ~~I~~ will discuss the more major ones in this testimony. We urge the Congress to enact work incentive provisions in Title II, similar to those in Title XVI, despite the failure of the Council to make such a recommendation. We support the Council's recommendations to raise the substantial gainful activity (SGA) level and to raise the Title II Trial Work Period trigger amount. We also urge that the provisions deeming disabled adult children eligible for SSI and, therefore, Medicaid, be extended to those who lost their eligibility prior to July 1, 1987 due to the increased SSDI payments they received on the death, disability, or retirement of their insured parent.

Work Incentive and Title II Benefits

The ARC actively supported the passage of the "Employment Opportunities for Disabled Americans Act" in the 99th Congress. The Act was crucial in permanently authorizing the Section 1619 work incentive provisions which enable an SSI beneficiary who is working despite a severe impairment to continue earning at higher levels while still maintaining some measure of cash assistance and Medicaid benefits. The Act also greatly simplified Section 1619 so that individuals whose income fluctuates would be able to go back and forth between the Title XVI beneficiary categories as needed.

We are extremely pleased to see the increasing use of the Section 1619 program as evidenced in SSA's March 1988 Quarterly Statistical Report on Section 1619. ARC has worked to ensure that persons with mental retardation are aware of the program and we have extensively encouraged its use. More than 30,000 SSI recipients with disabilities are now taking advantage of the work incentives of Section 1619. People with mental retardation account for approximately 37 percent of 1619 (a) participants and for 21 percent of 1619 (b) participants. For those individuals, this means an opportunity to earn more while maintaining basic and necessary supports, increased independence, and their own contributions to the tax system and the Social Security system. For our nation, this means increased independence on the part of persons with severe impairments and a fostering, rather than a wasting, of individual abilities to work and contribute to our society as a whole.

The ARC believes that the Section 1619 program has given us ample proof that work incentives for people with severe disabilities who need continuing supports do contribute to increased independence on their part. We believe it is important to establish a similar work incentive program in Title II for people with severe impairments who need continuing supports while working. Although SSDI beneficiaries are insured workers or dependents of insured workers, their needs for continued cash and medical support while attempting to return to work (or work for the first time) are similar to those of persons using Section 1619. The current disincentive in SSDI is the loss of all cash benefits and, eventually, Medicare benefits when an individual begins to work and earn more than $300 a month. An individual's lack of ability to replace lost benefits with wages makes it almost impossible for the person to consider attempting work. Since no program exists in Title II parallel to Section 1619 the disincentive is still very great.

Although the ARC does not collect data in this area, we continuously receive expressions of concern from our members regarding the inability of a family member to risk working and losing their basic SSDI and Medicare benefits. We also receive numerous calls from people working with persons with mental retardation (such as job counselors) regarding sheltered workers who are unable to risk the benefits of supported or competitive employment because they are dependent on their SSDI cash benefits and Medicare. The General Accounting Office (GAO) report ("Little Success Achieved in Rehabilitating Disabled Beneficiaries") cites that over 90 percent of Vocational Rehabilitation counselors surveyed felt that adopting a sliding benefit scale for working beneficiaries and indefinitely extending Medicare coverage would result in more beneficiaries attempting to work. These are the two basic elements of the Section 1619 program and we believe it is now time to extend it to Title II beneficiaries.

We are disappointed that the Social Security Disability Advisory Council failed to recommend a Title II work incentive program similar to Section 1619. However, we are delighted that Representative Steve Bartlett (R-TX) and several of his House colleagues have decided to sponsor legislation to create that needed Title II work incentive provision. The ARC wholeheartedly supports passage of the "Social Security Work Incentives Act of 1988," H.R. 4680, in the 100th Congress.

Mr. Bartlett's bill would create a Title II work incentive program parallel to the Title XVI program. Beneficiaries would have an opportunity to earn over the SGA level without losing all cash benefits. They would also have the opportunity to maintain Medicare benefits. A special status, "disabled and working," would be similar to the special status of Section 1619. All Title II beneficiaries would have this opportunity. The trial work period and extended period of eligibility would no longer be necessary. A benefit offset of one dollar for every two dollars earned (above certain disregards) would be applied to all work, whether for work in the new "disabled and working" status or for work below the SGA level in the regular SSDI status. A special grandfathering provision is included to protect those individuals currently receiving SSDI benefits and working below the SGA level who have not shown the ability to earn above $250 per month. Since they are currently on the SSDI program and relying on their ability to earn to this capacity, they would not see a one dollar offset for each two dollars they earn unless they earn more than the $250 amount.

Adult Disabled Child Beneficiaries

While considering the "Employment Opportunities for Disabled Americans Act," Congress was made aware of a problem which affected persons classified as disabled adult children. These adult "dependents" with disabilities are entitled to Title II benefits when their insured parent(s) retires, becomes disabled, or dies because the dependents' continuing disability occurred during childhood. The benefit level for the disabled adult child is based on the benefit level of the insured worker. The benefit level is higher for the dependent after the worker dies than when the worker is disabled or retired. Many disabled adults who fall into this category are initially receiving SSI benefits. When the insured parent retires, dies, or becomes disabled, the individual is required under SSI law to apply for the Title II benefits to which he/she is entitled. These Title II benefits (or the increase in benefits when the parent dies) may be high enough to make the individual ineligible for SSI and, in most cases, also ineligible for Medicaid benefits. Individuals who lost SSI and Medicaid benefits were then faced with no medical benefits and a two-year waiting period for Medicare.

Congress recognized the problems faced by these individuals in circumstances over which they had no control. In the "Employment Opportunities for Disabled Americans Act," Congress mandated that those individuals who lose SSI benefits as a result of the Title II benefits received as adults disabled during childhood after July 1, 1987 would be deemed SSI eligible for purposes of Medicaid eligibility.

There continues to be a problem, however, for those individuals who lost Medicaid eligibility prior to July 1, 1987. Although most but not all would by now have completed their two-year waiting period for Medicare, they are still unable to receive some critical Medicaid benefits, such as long term care services for persons with developmental disabilities, on which many had depended. Again, the ARC does not collect data in this area, but we have been notified of situations where individuals were denied community-based group home placements because they lost their Medicaid eligibility. Recognizing that Medicare does not provide many of the same services for persons with developmental disabilities, we urge Congress to extend the same deeming of SSI (and, therefore, Medicaid) eligibility to those disabled adult children who lost SSI benefits prior to July 1, 1987.

H.R. 4680, as introduced by Representative Bartlett, contains a provision to cover these individuals. We wholeheartedly support this effort and urge the Ways and Means Committee to support it also.

Substantial Gainful Activity

The ARC supports the Council's recommendation to adjust the SGA level to reflect the average wage growth since the SGA level was last increased and to index the SGA level to average wage growth in future years.

The current substantial gainful activity level is extremely low. An individual working at SGA level (or $300 a month) is earning wages below the federal poverty line. The individual can reach that level of income in a month working 22 hours a week at minimum wage. For many individuals, the risk that their own earned income cannot replace necessary medical benefits is simply too great. The SGA level has not been increased since the beginning of this decade. If the SGA level is to remain an integral part of the disability determination process, it should at least reflect the inflation which has affected every other aspect of American society in the last eight years. If we were to look at eligibility using figures adjusted for inflation, some applicants whose incomes would have qualified them for benefits in 1980 would not qualify today because SGA has not kept pace with increases in wage scales and the cost of living. Public policy determined that persons unable to earn above certain levels of income should receive assistance. Inflation has been allowed to erode the public policy determination of what is an acceptable threshold level for that economic support. Certainly it is clear that an individual with severe disabilities earning $350 a month is likely to be in greater need of assistance in 1988 than a similar individual earning $350 a month in 1980.

Trial Work Period

If Representative Bartlett's bill were to pass, the issue of the amount of work which triggers a trial work period would be moot. However, in principle, we agree with the Council that the trial work period level, should it remain a part of the law, should be increased to the SGA level.

Conclusion

The ARC submitted testimony (May 4, 1987) to the Disability Advisory Council which included more recommendations regarding the SSI and SSDI programs and the interrelationships of these programs for persons who are dual enrollees. I would like to submit a copy of that testimony for the consideration of the Ways and Means Committee.

The ARC believes the time has come to make work opportunities more available to persons receiving Title II benefits. New provisions should be as parallel as possible to the existing Section 1619 program to ensure that persons receiving benefits on both programs are not unduly confused and to simplify understanding of the disability programs overall. We urge the Subcommittee to move quickly to consider Congressman Bartlett's bill, H.R. 4680, and to move it for passage this year.

Thank you for this opportunity to present our views. Should there be any questions please contact Marty Ford at (202) 785-3388. Thank you.

Chairman **Jacobs**. Well, I think this concludes our hearings. We thank you all for your contribution.

[Whereupon, at 12:55 p.m., the hearing was adjourned.]

APPENDIX

ANDY JACOBS, JR., INDIANA, CHAIRMAN
SUBCOMMITTEE ON SOCIAL SECURITY

RICHARD A. GEPHARDT, MISSOURI
SAM M. GIBBONS, FLORIDA
SANDER M. LEVIN, MICHIGAN
JIM MOODY, WISCONSIN

HAL DAUB, NEBRASKA
PHILIP M. CRANE, ILLINOIS
BILL FRENZEL, MINNESOTA

Ex Officio
DAN ROSTENKOWSKI, ILLINOIS
BILL ARCHER, TEXAS

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON SOCIAL SECURITY

DAN ROSTENKOWSKI, ILLINOIS, CHAIRMAN
COMMITTEE ON WAYS AND MEANS

ROBERT J. LEONARD, CHIEF COUNSEL
M. KENNETH BOWLER, STAFF DIRECTOR
SANDRA CASBER WISE, SUBCOMMITTEE STAFF DIRECTOR

A.L. SINGLETON, MINORITY CHIEF OF STAFF
KAREN R. WORTH, SUBCOMMITTEE MINORITY

June 8, 1988

Mr. David Rust, Associate Commissioner
for the Office of Disability
Social Security Administration
6401 Security Boulevard
Room 560 Altmeyer
Baltimore, Maryland 21235

Dear Mr. Rust:

Thank you for testifying before the House Ways and Means Subcommittee on Social Security at its May 26th hearing on work disincentives in the Disability Insurance program. Your comments were extremely useful to the Subcommittee.

I have several additional questions about your testimony to which I would appreciate having written responses.

First, it would be useful to the Subcommittee have some additional information about SSA's recent experience with the SSI work incentive program under section 1619. Specifically, I would like to know:

* How do individuals now entering section 1619 compare in terms of disability and age with those who entered the program initially?

* How does the experience of these later entrants compare with those who entered earlier in terms of their success rates and of the costs to the program?

* At what rate does SSA expect participation in section 1619 to increase in the future?

In addition, please describe the current difficulties, if any, which SSA is experiencing in its administration of section 1619. The Subcommittee is particularly interested in your views on the complexity of the program and the error rates you have experienced in administering it.

Finally, I would like to know whether, and how, SSA will modify the definition of Substantial Gainful Activity. Specifically, will you implement the Disability Advisory Council recommendation to index SGA for wage growth since 1980? If not, by how much will you increase SGA? When? Will you implement the DAC recommendation to increase to the SGA level the amount of monthly earnings that causes a month to be included in a disabled beneficiary's Trial Work Period?

Thank you for your assistance in providing the Subcommittee with this information. I would like to have your response by Friday, June 17th so that it can be included in the hearing record.

Sincerely,

Andy Jacobs, Jr.
Chairman

DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration
Refer to
Baltimore MD 21235

Honorable Andy Jacobs, Jr.
Chairman, Subcommittee on
  Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Jacobs:

Enclosed are SSA's responses to your questions for the record from the May 26 hearing on work disincentives in the disability insurance program.

Sincerely,

David A. Rust

David A. Rust
Associate Commissioner
for Disability

Enclosures

How do individuals now entering section 1619 compare in terms of disability and age with those who entered the program initially?

If we compare all section 1619 participants at two points in time--August 1985 and March 1988--we find that a slightly greater percentage of participants are over 30. In August 1985, 61 percent of the section 1619(a) participants and 55 percent of the section 1619(b) participants were under age 30. In March 1988, 59 percent of the 1619(a) participants and 49 percent of the section 1619(b) participants were under 30.

A similar comparison for disability is attached. One difference lies in the number of participants with mental disorders. In August 1985, 64 percent of the section 1619(a) participants and 48 percent of the section 1619(b) participants had a mental disorder. In March 1988, 71 percent of section 1619(a) participants and 59 percent of section 1619(b) participants had a mental disorder.

Attachment

Appendix A

Table A-13.--Percent of disabled participants 1619(a) and 1619(b) participants, by diagnosis, August 1985 1/

Diagnosis	All SSI recipients under age 65	1619(a) participants	1619(b) participants
Total percent................	100.0	100.0	100.0
Infectious and parasitic diseases........................	1.0	1.0	.9
Neoplasms........................	3.7	1.0	3.3
Endocrine, nutritional, and metabolic......................	4.0	3.4	2.6
Mental disorders			
Schizophrenic disorders.........	13.0	15.2	18.2
Other psychoses and neuroses....	10.5	8.2	11.2
Mild mental retardation.........	15.0	29.7	14.0
Other mental retardation........	7.1	4.9	2.9
Unspecified mental retardation..	2.0	5.9	1.8
Diseases of nervous system and sense organs			
Diseases of nervous system.....	6.7	7.0	6.4
Diseases of the eye............	2.9	.5	3.3
Diseases of ear................	2.6	8.6	11.7
Diseases of the circulatory system........................	8.9	2.7	4.5
Diseases of the respiratory system........................	4.3	—	1.1
Diseases of the digestive system........................	1.0	.5	.8
Diseases of genitourinary system........................	1.0	1.6	2.2
Diseases of musculosketal and connective tissues............	7.3	3.4	4.4
Congenital anomalies............	2.3	1.1	2.5
Injury and poisoning............	3.1	4.2	5.9
Unknown.........................	3.2	1.1	2.2

1/ Information on diagnosis of recipients is available from SSI source files only since 1982. Percentages shown are based on 5,400 disabled recipients (SSI 1-percent file), 158 section 1619(a) participants, and 2,160 section 1619(b) participants.

Table 6. Percent of SSI disabled recipients, 1619(a) and 1619(b) participants, by diagnosis, March 1988 1/

Diagnosis	All SSI recipients	1619(a) participants	1619(b) participants
Total percent	100.0	100.0	100.0
Infectious and parasitic diseases	.9	.9	1.1
Neoplasms	1.7	1.2	2.9
Endocrine, nutritional, and metabolic	4.3	1.3	2.3
Blood and blood forming organs	.5	.5	.6
Mental disorders			
Psychotic conditions	20.4	24.9	29.1
Neurotic disorders	7.0	7.4	7.4
Mental retardation	25.6	39.1	22.2
Diseases of nervous system and sense organs			
Diseases of nervous system	5.8	5.9	5.6
Diseases of the eye	3.3	.7	3.0
Diseases of the ear	1.9	7.9	8.4
Diseases of the circulatory system	9.0	1.9	3.1
Diseases of the respiratory system	3.4	.6	.9
Diseases of the digestive system	.9	.2	.7
Diseases of genitourinary system	1.0	1.2	1.8
Diseases of musculoskeletal and connective tissues	8.1	2.6	4.2
Congenital anomalies	1.3	1.2	1.2
Ill defined conditions	.9	.4	.6
Injury and poisoning	3.7	1.9	4.5
Other	.3	.2	.3

1/ Information on diagnosis of section 1619 recipients is available from SSI source files only for persons applying since 1982. Percentages shown are based on 6,454 section 1619(a) participants, and 7,050 section 1619(b) participants. Information on diagnosis of all disabled SSI recipients is taken from the June 1987 SSI 10-percent disability file.

How does the experience of these later entrants compare with those who entered earlier in terms of their success rates and of the costs to the program?

We do not have data comparing earlier and later groups, nor do we have data on program costs. We have completed several studies that tracked success rates for a group of people who were section 1619 participants at quarterly intervals. Success was defined as either an earnings level high enough to leave the section 1619 program or no longer using Medicaid or needing Medicaid coverage. Administrative records were obtained 3 months after the quarter began to identify program status changes. This study revealed that:

-- Of the 13,890 June 1987 section 1619 participants, 330 (2.3 percent) became ineligible for SSI as a result of their work efforts by September. Another 50 participants earned enough that they were no longer eligible for an SSI cash payment but retained eligibility for Medicaid.

-- Of the 27,846 September 1987 section 1619 participants, 452 (1.6 percent) became ineligible for SSI as a result of their work efforts by December. Another 531 participants earned enough that they were no longer eligible for an SSI cash payment but retained eligibility for Medicaid.

-- Of the 30,191 December 1987 section 1619 participants, 398 (1.3 percent) became ineligible for SSI as a result of their work efforts by March 1988. Another 704 participants earned enough that they were no longer eligible for an SSI cash payment but retained eligibility for Medicaid.

At what rate does SSA expect participation in section 1619 to increase in the future?

Section 1619 participation has been increasing. The following table shows section 1619 participation at various points in time.

	section 1619(a)	section 1619(b)
December 1982	287	5,515
December 1983	392	5,165
August 1984	406	6,804
August 1985	816	7,954
January 1986	992	8,106
March 1987	1,381	10,500
June 1987	1,436	12,470
September 1987	12,752	15,094
December 1987	14,559	15,632
March 1988	14,649	15,704

The large section 1619(a) increase in September 1987 (over 700 percent) occurred because of legislation which changed the definition of a section 1619(a) participant. We are not attempting to predict future participation rates at this time.

In addition, please describe the current difficulties, if any, which SSA is experiencing in its administration of section 1619. The subcommittee is particularly interested in your views on the complexity of the program and the error rates you have experienced in administering it.

Difficulties cluster around the continuing disability review (CDR) requirement, and--for those who receive both Social Security disability insurance (SSDI) and supplemental security income (SSI)--the different treatment of work activity in the two programs.

1. As section 1631(j)(2)(A) is currently written, we may have to do multiple CDR's within a fairly short time span if an individual's income fluctuates, taking him in and out of 1619(b) status.

   We have determined administratively that such status change CDR's should not be done more often than every 12 months (barring some positive indication of improvement). We may find that every 12 months is still too often unless the individual has an impairment which is expected to improve.

2. On concurrent title II/title XVI cases, the different issues raised by work and earnings under the two titles can create administrative problems. Different handling under the two titles also carries potential for confusing the recipient. For example, work at the substantial gainful activity level that triggers entry into the 1619(a) program for the SSI portion of the person's benefits may trigger a trial work period or, later, benefit termination in the case of his title II benefits.

   We are carefully monitoring administration of 1619 provisions and have no indication of any pattern of administrative errors.

Finally, I would like to know whether, and how, SSA will modify the definition of substantial gainful activity (SGA). Specifically, will you implement the Disability Advisory Council (DAC) recommendation to index SGA for wage growth since 1980? If not, how much will you increase SGA? When? Will you implement the DAC recommendation to increase to the SGA level the amount of monthly earnings that causes a month to be included in a disabled beneficiary's trial work period (TWP)?

Both Secretary Bowen and Commissioner Hardy, as well as myself, are committed to finding ways to improve the disability programs administered by the Social Security Administration so that more beneficiaries will be encouraged to return to work. We agree that a reassessment of the SGA and TWP criteria is appropriate and we are currently doing this. I am confident that while our approach may not be in total agreement with the Council's proposal it will be viewed as being responsive to the intent of the Council.

Any changes in these criteria can be implemented without legislative action. This is because the Social Security Act presently gives the Secretary the authority to establish the SGA level for the disabled and to determine what services constitute a trial work month.

ANDY JACOBS, JR., INDIANA, CHAIRMAN
SUBCOMMITTEE ON SOCIAL SECURITY

RICHARD A. GEPHARDT, MISSOURI
SAM M. GIBBONS, FLORIDA
SANDER M. LEVIN, MICHIGAN
JIM MOODY, WISCONSIN

HAL DAUB, NEBRASKA
PHILIP M. CRANE, ILLINOIS
BILL FRENZEL, MINNESOTA

Ex Officio
DAN ROSTENKOWSKI, ILLINOIS
BILL ARCHER, TEXAS

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON SOCIAL SECURITY

DAN ROSTENKOWSKI, ILLINOIS, CHAIRMAN
COMMITTEE ON WAYS AND MEANS

ROBERT J. LEONARD, CHIEF COUNSEL
M. KENNETH BOWLER, STAFF DIRECTOR
SANDRA CASBER WISE, SUBCOMMITTEE STAFF DIRECTOR

A.L. SINGLETON, MINORITY CHIEF OF STAFF
KAREN R. WORTH, SUBCOMMITTEE MINORITY

June 8, 1988

John Affeldt, M.D.
Disability Advisory Council
c/o Social Security Administration
6401 Security Boulevard
Baltimore, Maryland 21235

Dear Dr. Affeldt:

Thank you for testifying before the House Ways and Means Subcommittee on Social Security at its May 26th hearing on work disincentives in the Disability Insurance program. The Subcommittee is grateful to you for a very thorough analysis of the DI program, as well as for your presentation to us of your key findings.

I have an additional question about your testimony to which I would appreciate having a written response. Page five of your prepared statement suggests that the disabled can be divided into three separate groups: those incapable of working, those who can become capable, and those who are now capable. It also suggests that SSA use this classification in pursuing separate policies with respect to each group. With what degree of certainty do you believe that these categories of individuals can be identified? On what general basis would you suggest that SSA attempt to draw these distinctions?

Thank you for this information. So that your response can be included in the hearing record, please respond by Friday, June 17th.

Sincerely,

Andy Jacobs, Jr.
Chairman

AJ/ef

DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration

Refer to:

Disability Advisory Council
PO Box 17064
Baltimore, MD 21203

AUG 11 1988

Honorable Andy Jacobs, Jr.
Chairman, Subcommittee on
Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Jacobs:

Enclosed is my response to your questions for the record from the May 26 hearing on work disincentives in Social Security's disability programs. Thank you for the opportunity to present the findings of the Disability Advisory Council to the subcommittee.

Sincerely,

John E. Affeldt, M.D.
Chairman
Disability Advisory Council

Enclosure

Response of John E. Affeldt, M.D., Chairman, Disability Advisory Council

Questions

Page five of your prepared statement suggests that the disabled can be divided into three separate groups: those incapable of working, those who can become capable, and those who are now capable. It also suggests that SSA use this classification in pursuing separate policies with respect to each group. With what degree of certainty do you believe that these categories of individuals can be identified? On what general basis would you suggest that SSA attempt to draw these distinctions?

Answer

Although the Disability Advisory Council considered the issue, it did not make a specific recommendation concerning classifying disability beneficiaries by their work capabilities. The Council believed that SSA had not collected the data that would have enabled the Council to recommend fundamental program changes in the area of disability determinations. Moreover, medical experts told the Council that categorization of individuals, except in cases of very severe disabilities or very minimal, nonsevere disabilities, was improbable because the current state of knowledge and technology does not enable the quantification of disabilities or the definition of categories of disability which reliably correlate an impairment with a particular individual's capacity to work. These same experts stated that work incapacity is not the direct result of physical or mental impairments alone, but rather is attributable to a variety of additional factors--psychological, economic, environmental and, perhaps most importantly, motivational.

However, in part because of the lack of existing data and knowledge in the area, the Council made a broad recommendation that SSA conduct demonstration and research projects to test the effectiveness of certain fundamental changes to the current disability determination process, including accelerating determinations, the use of case managers and provision for time-limited, partial DI benefits. The Council suggests that such research and demonstration projects would result in a number of improvements in the administration of the DI and SSI programs.

In its report, the Council's dividing the population of DI and SSI beneficiaries into groups relating to their work capacity was done solely for the purpose of examining the relevance to general groups of beneficiaries certain disability program features, such as continuing disability reviews, referral for VR services and work incentives.

ANDY JACOBS, JR., INDIANA, CHAIRMAN
SUBCOMMITTEE ON SOCIAL SECURITY

RICHARD A. GEPHARDT, MISSOURI
SAM M. GIBBONS, FLORIDA
SANDER M. LEVIN, MICHIGAN
JIM MOODY, WISCONSIN

HAL DAUB, NEBRASKA
PHILIP M. CRANE, ILLINOIS
BILL FRENZEL, MINNESOTA

Ex Officio
DAN ROSTENKOWSKI, ILLINOIS
BILL ARCHER, TEXAS

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON SOCIAL SECURITY

DAN ROSTENKOWSKI, ILLINOIS, CHAIRMAN
COMMITTEE ON WAYS AND MEANS

ROBERT J. LEONARD, CHIEF COUNSEL
M. KENNETH BOWLER, STAFF DIRECTOR
SANDRA CASBER WISE, SUBCOMMITTEE STAFF DIRECTOR

A.L. SINGLETON, MINORITY CHIEF OF STAFF
KAREN R. WORTH, SUBCOMMITTEE MINORITY

June 8, 1988

Mr. Dennis Smurr
Paralyzed Veterans of America
801 18th Street, N.W.
Washington, D.C. 20006

Dear Mr. Smurr:

Thank you for testifying before the House Ways and Means Subcommittee on Social Security at its May 26th hearing on work disincentives in the Social Security Disability Insurance program. Your comments were extremely useful to the Subcommittee.

I have an additional question about your testimony to which I would appreciate having a response for the hearing record. Page four of your statement suggests that Substantial Gainful Activity be raised for those DI recipients who are over age 50 as an alternative to providing them with vocational rehabilitation. Would you describe the rationale for this approach and explain how you envision such a system operating?

Thank you for your assistance. In order for your comments to be included in the hearing record, please respond by Friday, June 17th.

Sincerely,

Andy Jacobs, Jr.
Chairman

AJ/ef

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

July 14, 1988

The Honorable Andy Jacobs, Jr.
Chairman
Subcommittee on Social Security
House Committee on Ways and Means
B-317 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Jacobs:

Thank you for your letter of June 8th regarding my testimony on work disincentives in the Social Security Disability Insurance program, which you chaired on May 26th.

I am very sorry but I did not receive your letter until June 13th and that was the first day of my much long awaited vacation. I am back to work now and have gotten back into the groove having completed a thorough review of my in-box, only to find your letter.

Realizing the June 17th hearing record deadline has past, I would for my own edification, like to respond to the questions raised by my testimony and of specific concern in your letter. The question arose from my suggestion that the Substantial Gainful Activity be raised for those DI recipients who are age 50 as an alternative to providing them with vocational rehabilitation. You ask me to describe the rationale for this approach and explain how (I) envision such a system operating?

The suggestion stems from three observations. First, the current SGA of $300.00 per month is very unrealistic as a measure of not only work ability but more importantly liveability. Therefore, inherent in my suggestion is that the SGA be raised for all DI recipients not just those age 50 and older. Secondly, if a more realistic SGA level is established and properly indexed, this will serve to accomplish two important objectives - it will relieve much of the anguish, both emotional and financial, which the 50+ age group of DI recipients now face, plus it could serve to encourage this population group to seek minimum wage, part-time employment that could supplement their DI benefit while at the same time generating taxable earned income for state and federal treasuries.

In addition, we already know that the present job marketplace is not conducive to those age 50 and older, especially if they are disabled and unable to endure the rigors of full-time employment or unable to relocate. These very same individuals though may be able to perform part-time work, which in itself would not provide an adequate level of income but if coupled with DI would allow the individual an improved quality of life and level of subsistence. This population could in fact become the much needed labor pool of the ever-expanding service industry of tomorrow.

Part-time paid employment opportunities would not only improve the quality of life for a DI recipient, it would also improve the person's self-esteem and probably result in fewer Medicare dollars being spent per recipient per year because of decreased health maladies stemming from inactivity and one's preoccupation with a disability compounded by the aging process.

[redacted]

Because of the inadequacies of the current SGA level many recipients are forced to barter, trade, or engage in cash dealings much the same way as waitresses, waiters, some self-employed, or others who might "moonlight" to supplement their income status. All this shadow economy activity is outside the normal realm of traceable income generating payroll deduction type taxes or for that fact sales taxes; therefore, this represents lost taxable revenues to state and federal coffers. By raising the SGA to a level commensurate to some federally recognized and acknowledged wage rate basis for part-time employment much of this shadow economy activity could be curtailed and additional taxes could be realized.

[redacted] This would establish the individual's adjusted federal income base (afib). The next step would be to determine the ratio, expressed as a percentage value, between earned income and the adjusted federal income base. This value would be used to factor the amount of federal income tax owed dependent, of course, upon person's filing status and (afib), which for this purpose would be the same as taxable income as shown in the tax tables.

For example, a recipient has an afib of $20,000, of which $4,000 is earned income. Factoring this out gives us a percentage figure of 20. Reading the appropriate tax table for income of $20,000 indicates the person, if single, would owe $1,500 in federal taxes. Adjusting this figure by the 20% factor reveals that the individual would owe $300.00 in taxes. Depending upon how much tax was withheld from the person's payroll income would determine whether the individual owed additional taxes or received a refund, just like all other taxpayers.

Another, much less complicated, method for implementing a work incentive program would be to simply require each DI recipient age 50 and older to file a W-4 form indicating their estimated earnings and allowable deductions. The W-4 form would then serve as the basis of tax withholding for that individual. No additional forms, taxes, or refunds would be needed unless the individual's annual W-2 form indicated a large discrepancy in actual earned income from that estimated earlier on the person's W-4. If so, then additional taxes could be levied, a refund granted or some other system of carrying forward any imbalance which may have occurred could be developed.

[redacted] Rather, my suggestion arises from the statistics revealed by the Disability Advisory Committee Report for those DI recipients age 50 and over, coupled by my own understanding of living which a chronic disability and trying to work full-time in spite of my major physical impairments.

[redacted]s. Again, I thank you for your letter and for your interest in this matter that has serious implications for many Americans with chronic disabilities.

[redacted]

[redacted]
[redacted] Director

RDS:kaa

[Submissions for the record follow:]

May 27th., 1988
STATEMENT OF
EDWARD BRANCA, JR.
228 RAMAPO ROAD
GARNERVILLE, N. Y. 10923
TEL. 914 429-4723
SUBCOMMITTEE ON SOCIAL SECURITY
US. HOUSE OF REPRESENTATIVES
HEARING ON DISABILITY

I appreciate being able to share my experiences with the committee. I am a psychiatrially disabled worker. I am proud to be able to say I am employed part time as a clerical worker by Rockland Medilabs. Rockland Medilabs, which is headquartered in Valley Cottage, New York, is the largest medical laboratory in Rockland county. In addition to my earnings, I am receiving SSI. disability benefits. My SSI. benefits are reduced because I have earnings. I am proud to say that my working saves the American taxpayer over one hundred dollars each and every month. I'm also proud to say that I am paying taxes. Though I'm not earning enough money to pay income taxes, eighty five dollars and sixty four cents in Social Security taxes have been deducted from my pay checks thus far in 1988.

I was born on December 25th., 1950 and was disabled since early childhood. My illness (I am diagnosed as having manic-depression) prevented me from going to school. I was in and out of the Rockland Psychiatric Center from when I was eight until I was seventeen. When I was released as age seventeen (in 1968) I had low self esteem and felt I'd never be able to work. I was sure I'd be a bum and I'd live on the streets when my family, whom I was totally dependent on, was no longer able to care for me. I existed at home till 1980. Then I read a newspaper article which saved my life.

In September, 1980, I read of the chance reunion of a set of nineteen year old identical triplets who had been adopted separately at birth. The triplets' reunion moved me, and I decided to do what I could to try to change the laws to allow adoptees to obtain from their sealed adoption records the identities of their natural brothers and sisters. My state legislators, Assemblyman Thomas Morahan and state Senator Linda Winikow, introduced a bill and I enthusiastically lobbied to try to gain the bill's passage. The work I did lobbying made me realize that I could recover from my illness and could work.

I February, 1987, applied for vocational help from the New York state Office of Vocational Rehabilitation, (OVR.) and began treatment at the Rockland County Community Mental Health Center.

OVR. placed me in a "supported work" program called Project STEPs. Project STEPs. is a service of the Jawonio rehabilitation center. Because STEPs. is a supported work program, a "job coach" from Jawonio helps me adjust to the working world.

When I began working, the job coach was with me for my entire work period. Now she sees me twice a week during break.

A week after I began working, I encountered what I feel was by biggest problem, job stress, for the first time. Rockland Medilabs didn't put any pressure on me. I put pressure on myself. For months, the stress was torture. I was determined to stick it out, and stick it out I did. I am a making it in the world of work.

This spring, Rockland Medilabs increased my hours from fifteen to sixteen. A month later, my hours were increased to seventeen. I like working more hours and I like making more money. When my hours were increased to seventeen, I said to the job coach, "Less welfare. More workfare."

There are non-material rewards that come from working. Five mornings a week, I get up, eat breakfast and catch the bus to WORK. I have the satisfaction of knowing that I'm doing what everyone else does. Work brings much more than a paycheck. I have self esteem and self respect. I am studying to earn a high school diploma. I am asking women out. I am becoming an average citizen.

In January, I moved to a group home called Bernstein House. Bernstein House is s service of the Mental Health Association of Rockland County. I feel sorry for the residednts who aren't able to work. a life without work would be very boring to me. I am thankful that I am working.

I have goals. I will work full time and support myself. (I'll kiss SSI. goodbye!) I will leave the Mental Health Association housing system. God willing, I will fall in love and get married. (If you know of anyone who might be interested in going out with me, I'd appreciate your letting her know I'm here.) Labor Day used to mean that I couldn't go swimming any more. This year, and every year, Labor Day will be extra special. Thank God I am working.

--30--

Electronic Industries Association

Peter F. McCloskey
President

MAY 18 1988

May 16, 1988

The Honorable Andrew Jacobs
Chairman of the Sub-Committee on
  Social Security
House Ways and Means Committee
1533 Longworth Building
Washington, DC 20515

Dear Mr. Jacobs:

It is a privilege to write to you about the Social Security Disability Insurance Program, and the Disability Advisory Council mandated by the Congress to make recommendations that would assist disabled persons to be rehabilitated and restored to productive activity.

I am President of the Electronic Industries Association, (EIA) which is the major trade association representing electronic industries. Its 1,000 participating companies manufacture equipment, systems and component parts for communications, industrial, consumer and government end uses.

The Electronic Industries Foundation (EIF), a non-profit organization founded by EIA, has assisted almost 7,000 disabled persons (including SSDI beneficiaries) with job placement at an average starting salary of $13,767 and ranging up to $62,400. This has been accomplished through EIF's network of Projects With Industry. More than 1,000 companies currently participate. The impending labor shortages anticipated in the Department of Labor study "Workforce 2000" are expected to stimulate even greater participation by employers.

We have read with interest and enthusiasm the recent Disability Advisory Council report transmitted to the Congress on March 11, 1988 by the Honorable Otis R. Bowen, M.D., Secretary of Health and Human Services.

EIA and EIF wholeheartedly endorse the Council's legislative recommendation on page 57 which states that "Congress should authorize the Secretary to purchase Vocational Rehabilitation (VR) services directly from private sector VR facilities, Federal agencies and State agencies other than State VR agencies." We believe also that, pending enactment of necessary legislation, the Social Security Administration (SSA) should continue to expand its currently successful demonstration programs on an ongoing basis.

2001 Eye Street, N.W. · Washington, D.C. 20006 · (202) 457-4900 · TWX: 710-822-0148

In the Executive Summary, on page 4 of the Council's report, it is noted that SSA's present system for VR referral and reimbursement promotes neither competition among service providers, nor the involvement of employers in the formulation of job goals and the identification of job requirements and job skills. The report recommends that SSA promote active competition among public and private agencies and involve employers in the planning and delivery of VR services for Social Security Disability Insurance (SSDI) beneficiaries and Supplemental Security Income (SSI) recipients. We concur with this recommendation.

In support of its conclusion, the Council reports in Appendix R, on page 5, that SSA's experience to date with private-sector employment networks, programs, and providers has shown that:

- there are orginizations in addition to the State VR agencies that can help SSA's beneficiaries return to work;
- these organizations can provide a cost-effective alternative employment resource;
- established networks of employers and providers, such as the Projects With Industry network, ... can be particularly effective.

The Council also states on page 59 of the report its recommendation that:

> "State VR agencies should involve employers and unions in the design and structure of training programs so that service will be more likely to culminate in job placement. In this regard, the Council has been impressed with what it has seen of the Projects With Industry (PWI) demonstration programs funded by the Departments of Education and Labor. In general, these programs are effective in identifying specific job requirements in the community as well as in gaining the participation of skilled private sector managers, trainers and supervisors. The Council believes that States are not taking full advantage of this model as a means of vocational rehabilitation for Social Security recipients. We urge SSA to seek to encourage the development of PWI-type programs with appropriate SSA funding to serve DI and SSI beneficiaries."

We strongly endorse both of these findings.

As explained in the Executive Summary, it is essential that SSA's programs for people with disabilities be changed substantially over the long term. The Council expressed its belief that the DI and SSI programs should be restructured so as to assign a higher priority to encouraging beneficiaries to work than to declaring them unable to work. The Council stated further, on page 3 of the Executive Summary, that SSA's current Vocational Rehabilitation (VR) programs have a negligible impact on increasing the capacity of SSI and DI beneficiaries to work or return to work. Thus, maximum savings to the trust funds and general revenues from the provision of VR services are not being realized. The Council noted its concern that many beneficiaries who have the potential for gainful employment are not being enrolled in VR programs. As a result, disabled persons are being denied the means with which to improve the quality of their lives.

In summary, a minor amendment to the Social Security Act would authorize SSA to fund PWI and other providers of service to assist these disabled individuals to achieve independence through employment. In the meantime, if necessary, SSA could further demonstrate the effectiveness and substantial savings of such a provision by continuing and expanding the currently successful programs.

If you should desire additional information, you or your staff may wish to contact Mr. James T. Magee, President, Electronic Industries Foundation.

Sincerely,

Peter F McCloskey

Peter F. McCloskey
Chairman
Board of Trustees
Electronic Industries Foundation

STATEMENT OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES, SUBMITTED TO THE SUBCOMMITTEE ON SOCIAL SECURITY, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES ON THE FINAL REPORT OF THE SOCIAL SECURITY DISABILITY ADVISORY COUNCIL, June 8, 1988.

This statement is submitted by the National Association of Rehabilitation Facilities (NARF) for consideration of the Subcommittee and inclusion in the printed record of its hearing on the Final Report of the Social Security Disability Advisory Council.

NARF is the principal national membership organization of facilities providing medical and/or vocational rehabilitation services with membership of more than 700 such facilities. This membership ranges from highly sophisticated rehabilitation hospitals to small vocational facilities training and employing people with physical and/or mental impediments to employment. The purpose common to all member facilities is to assist the people they serve to live with maximum independence and where possible to support themselves and their families.

Many of our members routinely provide vocational evaluation and training, work hardening, placement and similar services to disabled persons referred by workers compensation carriers, state and local mental health and retardation programs, state vocational rehabilitation agencies and other sources. Such referrals include persons who have been determined to qualify for benefits under the Social Security Disability Insurance and the Supplemental Security Income programs. The role of such facilities in the vocational rehabilitation process is described briefly on page 36 of the Disability Advisory Council's report.

The Council's report is a very useful and constructive effort. It provides a good description of the dynamics of the VR process and the inherent limitations on the capacity of the current system to effect the rehabilitation and employment of SSDI and SSI beneficiaries. This statement will focus on those elements of the report that deal with the potential for improving rates of placement and cessation of cash assistance. NARF's member facilities have more "hands-on" experience with the VR system and the people it serves (and doesn't serve) than perhaps any other participant in the process.

The Council's report makes certain salient findings. The present system of beneficiary rehabilitation is not effective in returning people to work and reducing benefit costs. There are two areas in which things can be improved: the administration and funding of the VR process and the provision of incentives (and elimination of disincentives) for individual beneficiaries to return to work. Finally, the focus of any reformation of the system should be on returning beneficiaries to work and thereby save money for the Disability Trust Fund and the Treasury. NARF supports the central findings and recommendations of the report. This statement addresses specific actions that can be taken to expand rehabilitation services, return people to gainful employment and save money for the Trust Fund and the Treasury.

As documented in the report, the present system is not working. It is hampered by a conflict in objectives within State VR agencies and the policy of reimbursing such agencies only for cases where the beneficiary achieves substantial gainful activity (SGA), and goes off cash assistance. The report notes (page 35) that State VR agencies are under a statutory directive in the Rehabilitation Act to give priority to serving persons with more severe disabilities. The objective of the SSDI/SSI beneficiary rehabilitation programs is to return people to work at a cost that is commensurate with the savings in benefits. This dictates deliver of services to persons who offer the greatest potential for rehabilitation. Since present law requires that all services be initially funded by State VR agencies out of federal funds available under the Rehabilitation Act and State matching money, this conflict is a very real one. The present beneficiary rehabilitation program tries to "piggy-back" on the federal-State VR program. The result is decidedly unsatisfactory and ineffective. Rehabilitation of SSDI and SSI beneficiaries should be addressed through a separate mechanism which has clarity of purpose and funding.

Clarity of purpose can be achieved by authorizing and directing the Social Security Administration to purchase VR services directly from rehabilitation facilities and others. The recommendation is included in the Council's report (page 47), but not further developed. We believe that direct referral coupled with payment for services can result in a significant increase in rehabilitation of SSDI and SSI beneficiaries.

There is a clear public interest in expanding the scope and effectiveness of the beneficiary rehabilitation program. In light of the proven value of rehabilitation services and placement rates, it is tragic that so few SSDI/SSI beneficiaries are returned to substantial gainful employment. The Council's report stated that only .5% of persons who are adjudged disabled subsequently go off the rolls as a result of reaching SGA. There are certainly actions that can be taken to mitigate disincentives to work. These will be helpful. But, we suggest, the most significant action that can be taken is to expand rehabilitation and placement services. The Council's report recommends more services, but its only recommendation for increased expenditures in on page 49 where it suggests that SSA should pay for evaluations. We certainly support this recommendation, but suggest that there is no way to expand rehabilitations without spending money for services. The report recommends a number of changes in the performance of the VR system relative to SSDI and SSI beneficiaries, but does not indicate how these are to be funded. Presumably, the present mechanism is to continue. If State VR agencies are to be more aggressive in serving SSDI and SSI beneficiaries, they must reduce service to others, an unsatisfactory state of affairs.

The report is ambivalent on the question of priority of service. The Council states on page 45 that the goal of the program should be to return the maximum number of beneficiaries to gainful employment and that federal expenditures are justified as long as the savings are greater. However, in the following paragraph the Council states that severely disabled beneficiaries should have the same access to VR services as non-beneficiaries, while recognizing that such services are more costly than the average. There is a contradiction here. It is a contradiction that will continue to limit the beneficiary rehabilitation program so long as VR agencies are the only channel for service and they are only reimbursed for successful cases.

The beneficiary rehabilitation program that existed prior to 1981 was sound in concept, but flawed in execution. The concept of investing in rehabilitation instead of perpetual cash assistance is both good economic policy and good social policy. The program foundered because differing criteria used by SSA and state VR agencies led to confusion of goals and the failure to make specific linkage between expenditures for rehabilitation and the prospects for savings.

Expenditure of funds from the DI Trust Fund and the Treasury for rehabilitation of SSDI and SSI beneficiaries is justified by the prospect of saving future benefit payments. In the absence of a demonstrable benefit from such expenditures the political will to support the program erodes, as it did in 1981. Therefore, administration of the program must focus on this objective.

Similarly, such a rehabilitation program should be of a magnitude sufficient to realize the potential for human and economic savings in this course of action. NARF submits that the best course is to redesign the beneficiary rehabilitation program, rectifying the deficiencies identified by the Council's report, but also providing sufficient purchasing power to make the program effective and significant.

We suggest that the elements of such a program are as follows:

1. Separation of Funding of the Beneficiary Rehabilitation Program from the VR System.

We strongly recommend that funding of the beneficiary rehabilitation program be separated from the VR system. So long as services are financed from VR monies with no guarantee of reimbursement there will be little incentive for state agencies to take SSDI and SSI cases and there will continue to be confusion as to the criteria to be followed in selecting cases for evaluation and services. Continuing to try to "piggy-back" on VR funding guarantees that expenditures for rehabilitation of SSDI/SSI beneficiaries will be nominal. The government is now spending over $35 billion annually on cash assistance for approximately 7 million SSDI and SSI beneficiaries. If even 1% can, through the provision of effective rehabilitation services, achieve substantial gainful employment the savings amounts to $350 million per year. With this kind of money at stake it is not prudent to continue a program which is inherently limited.

2. SSA should be Authorized and Directed to Purchase Rehabilitation Services from Rehabilitation Facilities.

The Council's report recommends (page 47) that SSA be authorized to institute direct referral to rehabilitation facilities. This should be a cornerstone of restructured program of services. The Council notes that adoption of this practice will improve quality of service. Beyond that, a primary advantage of direct referral is that it can produce clarity of purpose. Evaluations should be geared to the potential for restoring the person in question to substantial gainful activity (the definition thereof is discussed below). Services should be delivered to those who possess the capacity to attain this level of income, if rehabilitation services are rendered. Evaluations should be made in relation to the criteria contained on page 45 of the report, ie. placement of the maximum number of beneficiaries in gainful employment and expenditure of trust funds and general revenues in a cost effective manner.

Any such program can and should be designed to involve beneficiaries in the development of their individual rehabilitation plans and should included procedural safeguards, such as rights of appeal and due process for beneficiaries.

Direct referral and purchase of services can be accomplished by establishment of a rehabilitation element within SSA, through contracts with facilities and/or case management services or establishment of discrete units within VR agencies.

3. Provide Adequate Funding.

The potential for saving money by rehabilitation of SSDI/SSI beneficiaries is so great that the Congress should be willing to invest some money in the concept. The present practice of payment only in the case of successful rehabilitations should be replaced by one or more funding mechanisms that will support a substantial enlargement of services. For the reasons set forth above the present program is inherently limited by the willingness of state VR agencies to risk VR money on such beneficiaries. The finite limits on VR money, the expanding demands on such funds from other populations and the uncertainty of recovery from the Trust Fund and SSI funds means that the program as presently structured will always be severely constricted. Expenditures in scale to the potential savings should be authorized. We suggest not less than $100 million, which is only 1/5 of 1% of cash assistance payments in FY 1988. The Council's report indicates that the average rehabilitation cost is approximately $6,000 per case. Thus, $100 million will provide for services to between 16,000 and 17,000 beneficiaries, or about 1/5 of 1% of those on the cash assistance rolls. Payment for more evaluations would cut into this number.

If, and as, it is established that the purchase of rehabilitation services at this level is cost effective funding should be increased until there is evidence additional increments of funding is not resulting in savings to the government.

4. Experiment with Different Forms of Payment for Services.

The preferred course on funding is to provide payment for services whenever there is a reasonable expectation that the services will result substantial gainful activity. There is no system or set of criteria that will produce a 100% success rate. It is penny-wise and pound foolish to pay only for successful cases and then at cost. The result is that very few people obtain services and fewer go off cash assistance.

We suggest that SSA should authorize to commit funds for rehabilitation whenever an evaluation indicates potential for rehabilitation. If it is not politically feasible for the government to risk funds on rehabilitation services without a guaranteed result, or to test the results of alternate modes of payment, we suggest some alternatives.

NARF has attempted to interest the Social Security Administration is a demonstration project to test the merit of direct referral and a payment mechanism that makes the connection between rehabilitation and savings to the DI trust fund explicit. We have proposed that rehabilitation facilities be permitted to evaluate and provide services as appropriate to such beneficiaries and be compensated out of savings to the government from the cessation of benefits. This is a variation on the "payment for successful cases" theme of the present system, with three major differences. First, payments would be made to facilities rather than state VR agencies (although the latter could continue to operate in the present mode). Second, payments to facilities would be made if and when beneficiaries served go off cash assistance. Third, payments for such services would be determined as a percentage of amounts that would otherwise have been paid in benefits. Implementation of this concept would place the risk of unsuccessful efforts to rehabilitate SDI and SSI beneficiaries with facilities. It would also require facilities to make very explicit judgments about the costs of rehabilitation relative to the prospects for success and the resultant savings to the DI Trust Fund and the Treasury.

SSA has not been approved this idea as a demonstration project. The primary concerns appear to be concerns over administering payments to facilities and whether facilities will make undue "profits" on successful cases. We are continuing to work with SSA to explore alternatives for payments which will provide a "risk-reward" ration favorable enough to stimulate a significant volume of services. SSA is, we believe, interested in exploring new ideas in this area and we are optimistic that a funding mechanism that is acceptable to all parties can be devised.

As a variation on this theme compensation for successful cases could be pegged at cost plus a factor, say 30%, to provide an incentive for facilities to accept the risk for the unsuccessful cases that will inevitably occur. Whatever mechanism is chosen to determine the level of payment for services, the amount must include some amount over the cost of the service. So long as payment is made only for services that result in a beneficiary showing substantial gainful employment the rate must contain a substantial premium to recognize the inherent risk that the beneficiary will not reach SGA. The higher the amount, the more people who will receive services.

SSA should test the cost-effectiveness of these and possibly other payment models to see which produces the best cost/benefit ratio.

5. Maintain the Present System.

In addition to the innovations outlined in points 1-4 above the present system should be maintained. It is producing some results and nothing is to be served by terminating it.

6. Eliminate or Mitigate Disincentives to Rehabilitation.

NARF generally endorses the analysis and recommendations in Chapter 5 of the Council's report relating to incentives and disincentives to work. We offer some specific suggestions, based on the experience of rehabilitation facilities in serving SSI and SSDI beneficiaries.

The definition of substantial gainful employment should not be less that benefit levels. There is little incentive to work when the result is to make less than SSDI and SSI benefit levels. The Council recommends adjustment of SGA levels to more realistic levels, to reflect changes in the cost of living and to phase out the differential between blind and other beneficiaries. All of these are sound recommendations and should be pursued. The concept of reducing benefits on a sliding scale so that a dollar of earnings is not fully offset by a loss of benefit is also valid.

NARF endorses the idea of not counting earnings in a VR program against the trial work period.

The experience of many of our member facilities suggests that the major impediment to rehabilitation of SSDI and SSI beneficiaries is the potential loss of Medicare and Medicaid coverage. Most such people have continuing health problems which make private health insurance either unavailable or expensive. The cost of group coverage for employers makes placement difficult. Anxiety about the loss of health care coverage is a powerful disincentive to employment. The Council suggests that there be a study of a "buy-in" to Medicare for DI beneficiaries who return to work (page 71). This is an idea that should be explored, but it is likely that the cost will be prohibitive for many marginal workers.

We suggest that the cost of continuing Medicare and Medicaid coverage may be the price of employment and cessation of cash assistance. At a minimum such eligibility should be continued for a period well beyond the trial work period and, we believe, permanent eligibility, except perhaps in cases of full medical recovery from the condition causing disability, would be a good investment. Confidence that he or she will have medical coverage is a great source of comfort to a person who is struggling to reenter the competitive economy. From the government's perspective saving only the cash assistance that would otherwise have been paid is better than not saving anything at all. H.R. introduced by Congressman Steve Bartlett incorporates this concept.

We offer these suggestions as extensions and variations on the themes in the Council's report, not in contrast to them. The Council is to be commended for a through and thoughtful job. We hope that the Subcommittee and the Congress will proceed with legislation to implement the report and the suggestions made in this statement.

STATEMENT OF GEORGE J. MERTZ, PRESIDENT
NATIONAL INDUSTRIES FOR THE BLIND

National Industries for the Blind (NIB) is pleased to have an opportunity to submit comments to the House Committee On Ways And Means, Subcommittee On Social Security on the recommendations proposed by the Disability Advisory Council of the Social Security Administration. NIB is a national nonprofit organization incorporated in 1938 in response to the passage of the original Wagner-O'Day Act, amended in 1971 as the Javits-Wagner-O'Day (JWOD) Act (P.L. 92-28). Under this act NIB has functioned (for 50 years) as the designated Central Nonprofit agency for qualified workshops for blind people.

Currently there are 82-associated agencies in 35 states, the District of Columbia and the Commonwealth of Puerto Rico, which operate 106 workshops. These workshops provided employment services for 6,361 blind and multihandicapped blind people in Fiscal Year 1987. The 82-associated agencies provided rehabilitation, social, educational, employment, and related services for 104,599 blind and visually impaired children and adults during the same period. While a seemingly small number of individuals when compared to all disabled Americans, it represents a significant portion of the estimated 600,000 Americans who are legally blind.

Both the Bureau of the Census and the National Center for Health Statistics have estimated that 70-75 percent of Americans with a serious visual impairment are not working. Furthermore, 69 percent of these individuals are not counted in the labor force, as they are not actively seeking employment. If applied to any other identifiable group, these figures would generally be considered a national disaster. The fact that it is not, may be indicative of the depth of the problem.

There are some abundantly clear reasons for such a high percentage of blind individuals who choose not to seek employment. Among these are outright discrimination or a deeply held perception of discrimination; social, educational, and familial attitudes which result in decreased vocational aspirations by blind persons; and drastic changes in work force technology which may exclude blind persons as often as including them. However, one of the most concrete and readily identifiable problems is the disincentives to employment inherent in the current Social Security Disability Insurance (and Supplemental Security Income) program for blind persons. This program, even with recent legislative modifications aimed at developing incentives to employment, often results in not only decisions to remain outside the labor market but often times conscious actions to forego opportunities for increased earnings and promotions.

While the Disability Insurance program may present disincentives for individuals disabled by conditions other than blindness, NIB can testify only about its impact on blind and multihandicapped individuals employed in the NIB-associated workshops and to some degree those individuals who could potentially benefit from these workshops.

The extended experience of NIB leads to the conclusion that the current system of "Substantial Gainful Activity" determination has three primary negative results:

1. Individuals choose not to enter or reenter the labor market for fear of losing SSDI cash and medical benefits.

2. Individuals choose to work part time, exhibit high absenteeism, or reduce their productivity; thereby, reducing earnings in order not to exceed the Substantial Gainful Activity level.

3. Individuals will turn down promotional opportunities or request that salaries not be raised, if the promotion or raise would result in exceeding Substantial Gainful Activity.

NIB most strongly disagrees with the recommendation of the Disability Advisory Council to hold constant the earnings level (SGA) for current beneficiaries who are blind and reduce the earnings level for new beneficiaries who are blind. While recognizing the needs of individuals disabled by conditions other than blindness, freezing the SGA level for current blind recipients and reducing SGA for future blind recipients will only compound the disincentives to work for blind people. The disincentives as now constituted most directly effect those blind persons who, because of disability or other factors have reduced income potential. The blind persons who receive an employment service in the NIB-associated workshops tend to be an older, less educated, and more severely disabled sub group of blind Americans. Many of these individuals must make significantly greater effort to take part in the labor force even on a part time basis. These efforts should be supported and commended, yet the Council's recommendation would have the opposite effect. Hours worked would be reduced, productivity would decrease, and even greater numbers of blind persons would simply choose not to enter the labor market.

The implementation of such a recommendation would not only negatively impact on blind and multihandicapped blind individuals, but also on the programs and agencies which provide employment and related services. With respect to the NIB-associated agencies, please note the following potential ramifications of implementing this recommendation.

1. Upward Mobility and Affirmative Action programs within the associated workshops would be negatively impacted by an increased number of blind persons who might turn down offers of promotions for fear that the salary attached to the promotion would exceed SGA. Such Upward Mobility programs are mandated by law, have been directly expressed as a concern of Congress (House Government Operations Subcommittee on Employment and Housing-1983, 1987), and most importantly have been the historical practice of the associated agencies.

2. In order to qualify for participation in the JWOD program, a workshop must document that at least 75 percent of the direct labor hours are worked by legally blind persons. A frozen or reduced SGA level may result in difficulty in meeting this requirement, as blind workers may reduce their hours worked. The potential exists that a workshop would then lose its qualification for participation in the JWOD program, thereby, losing the ability to produce items for the Federal government which is the basic tool for employment. In fact, blind persons who are not current beneficiaries but are working on these items may lose their jobs and be forced to apply for SSDI, SSI, or both.

We do not believe that the Disability Advisory Council sufficiently studied these issues prior to making its recommendation. We do believe that the expressed concerns regarding persons disabled by other than blindness are legitimate and therefore, concur with the recommendation made by the American Foundation for the Blind (AFB) in its testimony presented orally and in writing before the subcommittee on May 26, 1988 by Mr. Scott Marshall. That recommendation is herewith restated:

> "We recommend that the SGA earning's level for all disabled persons be established by law and indexed at the level for aged 65-69 retirees, with a phase out of $1 of benefits for each $2 in earnings."

NIB concurs with all other recommendations proposed by the AFB and urges due consideration of each.

NIB is pleased also to have the opportunity to submit comments on the report of the General Accounting Office Social Security- "Little Success Achieved in Rehabilitating Disabled Beneficiaries" (GAO/HRD 88-11).

It is interesting to note that the recommendation of the Disability Advisory Council regarding SGA is significantly different from the recommendations of vocational rehabilitation field counselors as noted in the GAO report. Field counselors who have direct contact with disabled beneficiaries, generally recommend a sliding scale of reduced benefits as the most appropriate incentive to work. This more closely parallels the recommendation supported by NIB and AFB.

NIB supports the basic conclusions and recommendations in GAO/HRD-88-11. However, there are a number of significant factors not considered by the report. The report does not address the amount of social security, payroll, and related taxes paid into the system by individuals who work at less than SGA levels. Nor does the report address the indirect economic benefits of these individuals which are derived from the purchase of services, consumer goods, home ownership, and other factors related to community participation.

JOHN DONNELLY
VICE PRESIDENT
PUBLIC AFFAIRS
NATIONAL MULTIPLE SCLEROSIS SOCIETY

Mr. Chairman and members of the Ways and Means Subcommittee on Social Security. I am John Donnelly, vice president of public affairs for the National Multiple Sclerosis Society. Thank you for this opportunity to submit testimony on the Report of the Disability Advisory Council.

Multiple sclerosis is a chronic, often disabling disease of the central nervous system; the brain, spinal cord and optic nerves. It is believed to result from immune-system dysfunction. Due to its relapsing/remitting nature, the symptoms and the severity are highly variable, It is difficult to diagnose the disease or predict its course in individual cases. With multiple sclerosis, an individual can be anywhere from mildly to severely disabled for a time. This is often followed by a period of slight to complete improvement, during which time it is possible to resume working.

The National Multiple Sclerosis Society is dedicated to funding research into the cause, cure, and prevention of the disease. Through its ninety-seven chapters, the Society also provides services and education in every state in the country. Because the services we provide includes advocacy with regard to various federal and state programs, and employment assistance. we are submitting this testimony.

I would like to begin my comments on the Report of the Disability Advisory Council by complimenting the Council. The Report is an excellent document that provides useful background analysis and recommendations. While we agree with most recommendations, these comments are to alert you to our concerns in the areas of establishing and maintaining eligibility for DI and SSI benefits. work incentives and disincentives, problems in obtaining accurate information on SSA disability programs, use of medical specialists, vocational rehabilitation, and data collection.

The Society, having worked closely with this subcommittee, would like to commend it for its efforts to deal with the problems enumerated within the Report. We also want to thank you, Mr. Chairman, for pursuing the passage of the "extended period of eligibility" provision in the 1987 budget reconciliation bill.

ESTABLISHING AND MAINTAINING ELIGIBILITY FOR BENEFITS

A) Establishing A Primary Purpose For Disability Programs

The fundamental purpose of disability programs needs to be decided. We agree completely with the statement that DI and SSI programs should not be viewed as "premature retirement" programs but should be based on the principle that many people with disabilities, if provided with timely and appropriate services. can work and should be encouraged to do so.

Currently, however, there is an underlying contradiction that needs to be resolved· to qualify for benefits an applicant must be totally and permanently disabled, and prove the inability to engage in "substantial gainful activity" over a twelve-month period: but once eligibility has been established, the applicant is strongly encouraged to work--thereby disproving the premise of his hard-earned eligibility. This leads to fear and distrust of the system, and discourages the newly eligible beneficiary seeking work. While this obviously is not intended, it is the reality for many beneficiaries.

As a means of resolving the conflict for one segment of the beneficiary population, the National Multiple Sclerosis Society urges the committee to consider modifying the standards of eligibility so as to take into account the nature of relapsing/remitting diseases like multiple sclerosis. This would permit these individuals to work when able, during a twelve month period, and still be acknowleged as permanently disabled, should he meet the requirements in the medical listings. In other words, we believe the disease should be recognized as permanent even though the symptoms come and go.

B) Simplifying The Eligibility Process

Related to the above recommendation is the problem delineated in this section and in Chapter 6 of the Report on the difficulty in establishing initial eligibility. People with multiple sclerosis, a permanent impairment, should not be subjected to extensive procedural difficulty to prove they are qualified for benefits. As the report states, this contributes to distrust and unwillingness to risk benefits once eligibility is established. Everyone's interests will be served by simplifying the eligibility process.

C) Unavailability of Health Insurance at Critical Times
Upon becoming eligible for disability benefits, there is a two-year waiting period for Medicare. For many this comes at precisely the time when their need is most acute--when their condition has just forced them out of the workforce. When most in need of health insurance, many cannot get coverage because of their pre-existing condition. Even if continued coverage is available through COBRA or standard conversion from employer group coverage, the fact that they have no income may preclude purchase of an expensive converted policy.

SSDI WORK INCENTIVES AND CONFUSING SOCIAL SECURITY REGULATIONS

A) Unavailability of Health Insurance as a Work Disincentive
In regard to Chapter 5, Issues Relating to Work Incentives and Disincentives, we urge adoption of most of the recommendations. We disagree, however, with the finding that loss of benefits, cash and medical, is not a significant disincentive to work. This may be so with many people with disabilities who have stable conditions, but it is not true for people who have multiple sclecosis. The following is an excerpt from an independent economic report commissioned by the National Multiple Sclerosis Society in 1987 entitled "Employment Incentive Provisions of Disability Benefit Legislation Affecting Beneficiaries with Multiple Sclerosis: The Financial Implications of Proposed Reform:"

> Because of the great difficulties that many people with MS experience in qualifying for disability benefits, many of them would be reluctant to take any overt act, such as accepting a part-time job, that might lead to an official review of their eligibility for benefits. Also, many of them have been unemployed for some time and their job skills have become obsolete. Although retraining facilities may be available, the effort, discipline, and perhaps financial costs involved, would dissuade many of them from seeking such training. Finally, all of the persons in this group are, to some extent, disabled. Many of them are over 40 years old, and most of them would want part-time rather than full-time jobs. This means that, taken collectively, they would confront most employers' preferences for non-disabled, younger, full-time employees. These biases are well-known, and this knowledge in itself would discourage many otherwise qualified persons with MS from trying to reenter the job market.
>
> The reluctance of MS beneficiaries to seek work in the absence of incentives is documented by a published Wisconsin study of people with disabilities. It reported that two of the greatest obstacles identified by study participants were: "unstable health conditions" and "fear of losing medical benefits". Study participants were grouped into sixteen disability-specific categories, plus a 17th category for "all others". On both "unstable health conditions" and "fear of losing medical benefits", the proportion of participants in the MS category indicating that the obstacle was a considerable problem was higher than for any of the other sixteen categories. (Bob Griss, Report on Health Care Coverage for Working-Aged Persons with Physical Disabilities: A Key to Reducing Disincentives to Work, Department of Health and Social Services, State of Wisconsin, December 1985.)
>
> A related unpublished finding of the study found that on the survey question "Would you choose to work if the benefits which you are eligible for by not working would exceed the income which you could earn?," a higher proportion (55 percent) of respondents with MS answered "it depends" than was found for any of the other categories. Among all respondents, this response was

> supplied by only 26 percent of respondents. In sum, there appears to be far greater ambivalence, and a greater need for certainty or reassurance (incentives) among beneficiaries with MS than among other disease and disability groups. As indicated, the contention of the NMSS and physicians and others familiar with MS, is that this ambivalence is due to the unique vagaries of multiple sclerosis.

A case in point is Joyce L. of Georgia. Last year, after this Committee's proposal of a lengthened period of "extended eligibility" became law, Joyce called the National Multiple Sclerosis Society and said it provided the incentive needed for her to seek re-employment on a full-time basis. The three years instead of 15 months seemed to give her the confidence to test her abilities. (Unfortunately, this incentive has not had the widespread positive effect for which we hoped, seemingly because the variable nature of multiple sclerosis leads to such uncertainty about the future that for many with the disease, anything short of permanent eligibility is insufficient.)

Three weeks ago, Joyce called us again. She had completed seven months of her trial-work period and found she was in line to become employed full-time. Both she and the employer started questioning the health-insurance issue. Although she still had approximately 3 1/2 years of Medicare coverage even if she went back full time, the question became "what happens afterwards?" Joyce does not know whether the employer's health-insurance plan will cover her if she takes the full-time job. It is Hoped the Report's recommendations will be adopted by the time her Medicare runs out, and either she or the employer will be able to buy-in to Medicare.

B) Difficulties in Obtaining Accurate Information from SSA
It is interesting to note here that when our Georgia chapter attempted to find out from the local SSA office what coverage and/or benefits would continue for Joyce, they were told that there would only be 36 months of extended eligibility and no continuation of Medicare. (This of course, is incorrect.) This example makes a clear point of the need to improve Social Security public information services as noted by the report.

C) Improving Public Understanding of SSA Disability Programs
To improve public knowledge about the Social Security programs, its rules and incentives, SSA ought to consider providing grants or developing joint education programs with voluntary health agencies and other organizations.

D) SSI Style "Permanent Eligibility" is Needed for the DI Program
The National Multiple Sclerosis Society supports the development of stronger work incentives. Most people with MS are diagnosed between the ages of 20 and 40, have a history of working, and a financial and psychological need to work. Based on the SSA's reported success with the latest work incentive in Section 1619 of the SSI program, we believe the reinstatement provision of extended eligibility should be incorporated in the SSDI program for people with chronic diseases with relapsing/remitting symptoms. This would alleviate the uncertainty and fear that discourage many beneficiaries from taking employment. Beneficiaries with incurable diseases that do not improve should not be required to re-establish eligibility.

E) Increasing Substantial Gainful Activity and Trial-Work Earning Levels
We strongly support increasing the SGA level to $700 as a truer indicator of an individual's ability to be self-supporting. Likewise, raising the trial-work level from $75 to $300 per month is a better measure of success. We support the majority of the other recommendations in this chapter as well.

F) Employment-Related Early Intervention
A final point we would like to make is that the Report does not deal with the need for early employment-related intervention. A program designed to provide appropriate skill training for individuals with progressively disabling diseases is needed to help individuals retain their jobs and preclude the need for Social Security disability benefits.

A research project currently in operation in Australia documents that people with multiple sclerosis leave employment close to the time when they are diagnosed or when a significant change in symptoms occurs. We suggest SSA might intervene prior to individuals actually leaving employment or being eligible for disabilitly benefits. This is a new approach not discussed in the Report. If an early-intervention program existed, SSA might help people avoid becoming disability beneficiaries long before they might need to be. We recommend evaluation of such a "stitch-in-time" program dealing with certain types of disabilities.

MEDICAL SPECIALISTS

We have one comment on Chapter 7, Use of Medical Specialists in Determinations of Disability. When the need arises for a consultative physician, specialists such as neurologists who are familiar with MS, and neuropsychologists who understand the problem of MS cognitive deficits should be engaged. Too often consultation is provided by otherwise competent physicians with no special knowledge of the complexities of MS. We strongly urge greater use of specialists with demonstrated expertise in various diseases.

VOCATIONAL REHABILITATION AND DATA COLLECTION

A) VR Employees Do Not Understand Relapsing/Remitting Diseases

As regards Chapter 4, Issues Related to Vocational Rehabilitation, we have several comments. The National Multiple Sclerosis Society hears complaints of prejudice against people with multiple sclerosis by state VR personnel. One possible reason VR employees may have difficulty dealing with people with MS is because exacerbations or disease progression may cause a set-back and the need for new VR. Some VR employees may view this as a failure when compared to results of one with a stable, disability who completes VR and moves on.

B) VR Has Less Success With People With A Lot of Job Experience

Another problem is that most people with multiple sclerosis have a work history and certain job expectations, whereas state VR agencies generally do best with people with little previous employment experience. Although jobs held by people with MS are as broad as can be found in the general poplulation, and because of the general age of onset is between 20 and 40, many are found in middle management and professional jobs.

Instead of trying to force people to develop skills for job vacancies, the VR effort should be to build on the talents and abilities of individuals and prepare them to deal with their disabilities on the job.

C) Postpone Sanctions Against Beneficiaries Who Refuse VR

The Report recommended enforcement of sanctions against beneficiaries who refuse to participate in VR programs. We agree that beneficiaries should be encouraged to avail themselves of VR services. We note, however, that fear of loss of eligibility, real or otherwise, is a powerful deterrent. This is why we recommend the need to clear up any underlying inconsistency in the purpose of Social Security disability programs and to extend indefinately eligibility for people with chronic diseases of a relapsing/remitting nature.

D) Provide VR To Young People in Nursing Homes

Where feasible and appropriate SSA should provide VR services to non-geriatric Social Security disability beneficiaries residing in nursing homes. SSA should bring to bear its influence on state VR agencies to accomplish this. It should not be assumed that confinement to a nursing home is by definition a total and complete dependency. Many younger nursing-home residents are forced into such institutions for lack of other options and would be capable of working with proper training. There are an estimated 6,000 - 12,000 people with MS under 60 now nursing homes, (some receiving SSDI or SSI), many of whom could work if helped.

E) Restore VR Reporting of Services

A final point on VR deals with the data-collection component of recommendations in this section and in the first section of the Report. The SSA should restore state VR reporting of services to Social Security disability beneficiaries, and should make the data freely available on a disease-specific basis. This would allow better coordination of services and activities with private help-related organizations like the National Multiple Sclerosis Society.

F) Medicare Date Should Be Made Available
In a similar vein, SSA should make Medicare disease-specific data on utilization and costs of services by and for its beneficiaries freely available to private help-related organizations.

CONCLUSION

Congress has many options and recommendations on which to act. The Report by the Disability Council is an excellent document. The National Multiple Sclerosis Society is pleased to have an opportunity to comment on the recommendations.

Mr. Chairman and members of the committee, as you plan for future legislation and changes, we hope you will keep in mind that there are various types of disabilities. What works for beneficiaries with stable conditions might not be appropriate for those with a variable conditions.

It is our wish that you will be able to legislate improvements in the Social Security disability programs drawing from the Report recommendations. Since we agree with most recommendations, these comments were drafted to alert you to our specific concerns.

Thank you.

Thomason & French

George H. Thomason
Robert S. French

ATTORNEYS AT LAW
164 OAKLAND AVENUE
SPARTANBURG, SOUTH CAROLINA
TELEPHONE (803) 582-5857

MAILING ADDRESS
POST OFFICE BOX 772
SPARTANBURG, SOUTH CAROLINA 29304

May 31, 1988

Mr. Robert J. Leonard
Chief Counsel
Committee on Ways and Means
U. S. House of Representatives
Room 1102, Longworth House Office Building
Washington, DC 20515

Dear Mr. Leonard:

I submit this original letter and six copies of written comments to be included in the official record on work incentives and disincentives in the SSDI Program.

1. I am a full-time private practitioner in South Carolina having been licensed since 1971 to practice law. A major portion of my practice has been devoted to Social Security and SSI disability claims. I have handled hundreds of Social Security disability claims at every level of administrative review and before the District Court of the United States and U. S. Court of Appeals. I am extremely familiar with the incentives and disincentives for work and rehabilitation which exist in the Social Security disability program and feel that I can offer comments which may be helpful to the Subcommittee.

2. Social Security frequently uses efforts at rehabilitation by disability applicants to deny disability claims. Therefore, a major disincentive exists for any applicant for disability to seek rehabilitative services or to re-train for other substantial gainful activity. Specifically, I have represented numerous younger individuals who have been injured in accidents. Their claims were first rejected by the state agency at the initial and reconsideration level with statements that the disability would not last for 12 months. The injuries sustained in the accident were severe and no treating physician could be certain of the length of disability. The physician was sure, however, that the disability applicant would never be able to return to physically vigorous work that had been performed prior to the accident. The disability applicant, having been rejected initially and on reconsideration, requests a hearing which is conducted before an ALJ. The applicant becomes involved in re-training through Vocational Rehabilitation because it is evident to the applicant that he or she will never be able to return to past relevant work activity. The applicant comes to a hearing before an ALJ and mentions that he or she is involved in re-training, classes at a

local community college, or participation in a Vocational Rehabilitation workshop. In every instance, the ALJ has taken efforts at rehabilitation and turned it against the applicant for disability benefits. The ALJ, in the unfavorable hearing decision, will usually say that a person who can attend class for one or two hours a day has demonstrated a capacity to sit, walk, concentrate, etc. Participation in the training course, instead of being credited to the applicant, is used for purposes of denying the claim. This has occurred on many occasions. I have also had a claim denied when a person was making more than $150 a month in a sheltered workshop. This person would never be able to work in a real job and was trying her best and "her best" was immediately seized upon as a mechanism for denying her disability application.

Therefore, the Social Security Administration should be prohibited from using efforts at re-training or rehabilitation as a device for denying a disability application. It happens all the time and it's wrong. Oddly, if these countless individuals had remained out of a rehabilitation program, their claims would have been approved.

3. State Vocational Rehabilitation agencies should be forbidden by law from denying rehabilitation services to an individual who has applied for Social Security disability benefits. Locally, Vocational Rehabilitation will not offer vocational rehabilitation services to an individual who has an active Social Security disability claim. Rather obviously, Vocational Rehabilitation only wants success claims or success stories. They see any individual who is applying for disability as having a low potential as a success story. Therefore they do not want people who are applying for Social Security to seek rehabilitation services. This happens all of the time. Services, in some instances, are conditioned upon dropping the disability application. This is a difficult choice for an individual who is suffering a severe economic hardship as a result of disability who, at the same time, hopes to work out of a disabling situation.

4. Trial work activity is a joke. There is an inconsistency between the amount of money that a person can earn and have it described as "trial work" and the other Social Security regulations which define higher amounts of money as evidence of capacity or incapacity to participate in substantial gainful activity. I currently have a claimant who is severely impaired and meets several listed impairments. Heaven only knows how she was able to get a job but she did. She made approximately $200 a month. This is way above the $75 a month limit for trial work. However, it is well below the dollar figure which is used by Social Security to consider that a person is participating in substantial gainful activity. Against impossible odds, the woman continued to participate in work activity and reported it faithfully to Social Security. What happened? They failed to cut off her benefits and she thought she was entitled to continued payment and now she is facing a $9,000 overpayment. If she had not been well motivated and had stayed at home she would not be involved

in a hopeless administrative quagmire. She is being pursued vigorously by Social Security in their efforts to get $9,000 from her. This is the best example of a disincentive that I have seen in 17 years. Most people are not going to risk the economic security of Social Security disability payments through the trial work trap that currently exists.

5. When I first began practicing law in 1971 Social Security would refer individuals to Vocational Rehabilitation for work evaluations. This was stopped almost immediately, in South Carolina, because the work evaluations generally produced highly favorable reports that made denying disability benefits difficult. The work evaluations almost conclusively define that a person is disabled. Social Security also had some very unusual contractual relationship with Vocational Rehabilitation which assured workshop evaluators that they would never be required to testify at Social Security hearings. This is the identical arrangement that exists contractually between Vocational Rehabilitation and medical consultants who do one-shot examinations for Social Security. Social Security goes to great lengths to ensure that evaluators and consultants will not be required to come to administrative hearings and discuss their written reports. In the early part of my practice this created considerable difficulty when we asked for a workshop evaluator to appear at a Social Security hearing a few miles away. Perhaps work evaluations would be helpful in assessing work capacity if the client who is being evaluated can have access to the evaluators who work for the Disability Determination Agency. The systems that have existed in the past do not give the appearance of being objective, fair, or unbiased. I felt that this was especially damaging to the integrity of the Social Security disability program. I also think that work evaluations can only be used in a limited number of cases because they are extremely costly and time consuming and most local Vocational Rehabilitation agencies have undergone economic cuts where they do not have the people to handle the additional requests that would be made for work evaluations.

6. Social Security has constantly been reminded of the importance of vocational testimony at administrative hearings when severe exertional and nonexertional limitations have been defined throughout the record. See Grant v. Schweiker, 699 F.2d 189 (4 Cir. 1983). This is only one court decision of many decisions which have reiterated the importance of vocational testimony at Social Security hearings. Interestingly, the utilization of vocational experts at Social Security hearings in this area has gone down. Many court remand cases in South Carolina instruct the Secretary to consider the vocational issues presented in the claim. Social Security should be encouraged to use competent vocational experts at Social Security hearings more frequently to comply with the fundamental legal principles that should be used in vocational evaluations at disability hearings.

7. Sliding scale benefit reduction should be brought into effect for the individual on disability who is trying to get off of disablity through rehabilitative programs or trial work. As mentioned earlier, trial work is a total failure. A sliding benefit reduction spread over a 24 month period of time would be an excellent mechanism for getting an individual from disability back into the work force.

8. Social Security should be willing to pay a fee, without question, for any disability applicant who wished to go to a private rehabilitation service. Private rehabilitation counselors existing in this area do an excellent job in trying to match handicaps with existing work possibilities. These fees are usually quite reasonable and private counselors seem to be more effective in actually finding work for a handicapped citizen. This should be encouraged whenever possible. State Vocational Rehabilitation agencies should be legally required to provide rehabilitation services to individuals who are disabled as a result of substance abuse (alcoholism). In recent years programs available to alcoholics have been cut drastically and funding has not been available to assist them with detoxification and rehabilitation. There should be some concentrated effort to help alcoholics recover.

CONCLUSION

Thank you for considering these observations. If I can provide any additional information please feel free to contact me.

With kindest regards, I am

Very truly yours,

THOMASON & FRENCH

GHThomason

George H. Thomason

GHT/jbp